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Transactions...

Associated physicians of Long Island

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E. H. Bartley.

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TRANSACTIONS OF THE

ASSOCIATED PHYSICIANS OF LONG ISLAND

VOLUME VII

JUNE, 1905, TO JUNE, 1906

BROOKLYN, N. Y.

ASSOCIATED PHYSICIANS OF LONG ISLAND

1906

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COMMITTEE ON PUBLICATION.

PAUL MONROE PILCHER, *Chairman.*
Frank Overton.
George H. Donahue.

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TABLE OF CONTENTS.

PAGE

Organization 5

Officers and Committees for 1906 7

Executive Transactions.

TWENTY-SECOND REGULAR MEETING, Oyster Bay, July 12, 1905.

Addresses 19
Report of Membership Committee 9
Communication of Board of Trustees 12
Scientific Session 13

TWENTY-THIRD REGULAR MEETING, Centre Moriches, October 21, 1905.

Report of Membership Committee 13
Scientific Session 14

EIGHTH ANNUAL MEETING (Twenty-fourth Stated Meeting), Brooklyn, January 27, 1906 14
Report of Membership Committee 15
Report of Secretary 15
Report of Treasurer 16
Report of Historical Committee 16
Report of Committee on Life Insurance and Relief Fund for Widows and Orphans 17
Annual Election of Officers 18
Scientific Session 18

Addresses.

Inaugural Address of the President, WILLIAM BESLEY SAVAGE, M.D. 19
Address by the President of the United States, THE HON. THEODORE ROOSEVELT 21

Scientific Transactions.

I. The Cure of Carcinoma of the Breast. By LEWIS STEPHEN PILCHER, M.D., LL.D. (Brooklyn) .. 25
Discussion by Drs. H. Beeckman Delatour, S. C. Blaisdell, J. S. Wight, and M. Figueira.

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PAGE

II. The Surgery of "Dyspepsia." By RICHARD WARD WESTBROOK, M.D. (Brooklyn) 34
Discussion by Dr. Henry A. Fairbairn.

III. The Conservative Treatment of Urethral Stricture. By G. MORGAN MUREN, M.D. (Brooklyn) 56
Discussion by Drs. John D. Sullivan and W. Maddren.

IV. More Rapid Correction of Lateral Curvature of the Spine (*Illustrated*). By WALTER TRUSLOW, M.D. (Brooklyn) 66
Discussion by Drs. William B. Savage, Elias H. Bartley, John D. Sullivan, and H. Beeckman Delatour.

V. A Brief Résumé of Recent Work in Diseases of the Urinary Tract By HOWARD A. KELLY, M.D. (Baltimore, Md.) 80

In Memoriam 89

Associated Physicians of Long Island.
Constitution and By-Laws 93
List of Officers from Its Organization 97
Officers, 1906 99
Roster for 1906 99
Honorary Members 111
Roster, Geographically Arranged 112

List of Portraits.

The President, Elias Hudson Bartley, M.D. ..... *Frontispiece*
The late Homer Lyman Bartlett, M.D. 89
The late Richard Henry Sullivan, M.D. 90
The late Heber Nelson Hoople, M.D. 90
The late Ezra Herbert Wilson, M.D. 91
The late George Ryerson Fowler, M.D. 92
The late Joseph Edgar Wells, M.D. 92

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ORGANIZATION.

"The Associated Physicians of Long Island" is an incorporated body which was organized at the Union League Club in Brooklyn, April 14, 1898, with Dr. Lewis N. Lanehart, of Hempstead, as Chairman, and Dr. Robert J. Morrison, of Brooklyn, as Secretary.

Its purpose was to bring into closer relationship the members of the various County Societies of Long Island. Its further purpose has been to supplement the work of the County Societies, and accomplish by concentrated action, if possible, the proper regulation of matters pertaining to the general hygiene of the Island, and to foster a higher ethical standard among its members. Another important result of its organization has been to bring together socially, as well as scientifically, the various medical and surgical workers of Long Island.

The meetings of the Association are held three times a year, the annual meeting taking place in Brooklyn; each meeting consists of three parts: a business session, a scientific symposium, and a dinner. Transportation to and from the place of meeting has always been furnished free by the Long Island Railroad.

The members of the Suffolk County Medical Society, the Queens-Nassau Medical Society, and the Medical Society of the County of Kings are eligible to membership in the Association.

The Suffolk County Medical Society is one of the oldest societies in the State, having been organized July 22, 1806. It holds two meetings annually, each consisting of a scientific and a social session. Its present membership numbers 81 physicians.

The Queens-Nassau Medical Society is a continuation of the Medical Society of the County of Queens. In 1899, Nassau County was formed out of that portion of Queens County not included in Greater New York; the legal steps necessary for a change of name were taken and, on July 5, 1899, The Medical Society of the County of Queens became the Queens-Nassau Medical Society. The number of active members is nearly one hundred, and meeting are held twice annually, in May and November.

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The Medical Society of the County of Kings was organized March 2, 1822. It holds meetings on the third Tuesday of every month excepting in July and August. Its present membership is 750 physicians.

The first regular meeting of the Association was held at Garden City, Long Island, June 8, 1898, at which the organization was perfected by the adoption of a Constitution and By-Laws and the election of officers. It was incorporated October 17, 1899, with the following Board of of Directors:

Dr. William Browning, Brooklyn.
Dr. Lewis N. Lanehart, Hempstead.
Dr. James M. Winfield, Brooklyn.
Dr. Robert J. Morrison, Brooklyn.
Dr. Arthur H. Terry, Patchogue.

The following meetings have been held:

1. Garden City, June 8, 1898.
2. Patchogue, October 8, 1898.
3. Brooklyn, January 21, 1899.
4. Garden City, June 22, 1899.
5. Central Islip, October 21, 1899.
6. Brooklyn, January 27, 1900.
7. Northport, June 16, 1900.
8. Easthampton, October 6, 1900.
9. Brooklyn, January 26, 1901.
10. Sag Harbor, June 16, 1901.
11. Garden City, October 19, 1901.
12. Brooklyn, January 25, 1902.
13. Islip, June 21, 1902.
14. Riverhead, October 18, 1902.
15. Brooklyn, January 24, 1903.
16. Southampton, June 13, 1903.
17. Garden City, October 17, 1903.
18. Brooklyn, January 23, 1904.
19. Central Islip, June 18, 1904.
20. Mineola, October 22, 1904.
21. Brooklyn, January 28, 1905.
22. Oyster Bay, July 12, 1905.
23. Centre Moriches, October 21, 1905.
24. Brooklyn, January 27, 1906.

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OFFICERS AND COMMITTEES FOR 1906.

OFFICERS.

President, Elias H. Bartley.
First Vice-President, J. Ensor Hutcheson.
Second Vice-President, H. B. Delatour.
Third Vice-President, Arthur H. Terry.
Secretary, James Cole Hancock.
Treasurer, Charles B. Bacon.

COMMITTEES.

Scientific.

T. R. French, Brooklyn.
J. H. Benjamin, Riverhead.
Frank T. De Lano, Rockville Centre.

Historical (Permanent).

J. S. Cooley, Glen Cove.
William Schroeder, Brooklyn.
Walter Lindsay, Huntington.

Publication.

Paul M. Pilcher, Brooklyn.
Frank Overton, Patchogue.
George H. Donahue, Northport.

Membership.

E. S. Moore, Bay Shore.
J. H. Barry, Long Island City.
W. P. Pool, Brooklyn.

Public Health.

Arthur C. Loper, Greenport.
Chas. M. Niesley, Manhasset.
J. M. Van Cott, Brooklyn.

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Legal.

A. T. Bristow, Brooklyn.
J. F. Bloodgood, Flushing.
W. H. Zabriskie, Glen Cove.

Entertainment.

Lefferts A. McClelland, Brooklyn.
George K. Meynen, Jamaica.
Henry L. Schilling, Brooklyn.
Fred. C. Merritt, Sayville.
Wm. A. Hulse, Bay Shore.

FORMER PRESIDENTS OF THE ASSOCIATION.

1898-1899—William Browning, Brooklyn.
1899-1900—Lewis N. Lanehart, Hempstead.
1900-1901—James M. Winfield, Brooklyn.
1901-1902—William B. Gibson, Huntington.
1902-1903—Calvin F. Barber, Brooklyn.
1903-1904—William H. Ross, Brentwood.
1904-1905—Robert J. Morrison, Brooklyn.
1905-1906—William B. Savage, East Islip.

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EXECUTIVE TRANSACTIONS

OF THE

ASSOCIATED PHYSICIANS OF LONG ISLAND.

Twenty-second Regular Meeting, held at Oyster Bay, July 12, 1905.

The President, Dr. William B. Savage, in the chair.

The meeting was called to order and the minutes of the previous meeting read and approved.

The President presented his inaugural address (for which see page 19).

The recommendations in the President's Address were referred to a Committee to be known as a Committee on Distribution, of which the Chairman of the Legal Committee should be a member. Drs. Fairbairn, Ross and Hewlett were named by the President as such a Committee.

At the close of the meeting this committee reported in favor of adopting the recommendations, which action was approved by vote of the Association.

Theodore Roosevelt, President of the United States, was introduced by President Savage, and made an address to the Association (for which see page 21).

REPORT OF MEMBERSHIP COMMITTEE.

The following names were reported by the Membership Committee and duly elected to membership:

James A. Somers, 32 Lafayette Avenue, Brooklyn.
Frederic J. Shoop, 316 Cumberland Street, Brooklyn.
Francis H. Bermingham, 132 Montague Street, Brooklyn.
Frank R. Baker, 540 Bedford Avenue, Brooklyn.
Warren L. Duffield, 99 Berkeley Place, Brooklyn.
Mathias Figueira, 14 Stuyvesant Avenue, Brooklyn.
Thomas R. French, 150 Joralemon Street, Brooklyn.

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Maurice T. Lewis, 414 55th Street, Brooklyn.
Alexander Rae, 117 Henry Street, Brooklyn.
George C. Straub, 846 St. John's Place, Brooklyn.
Thomas B. Hegeman, 2603 Newkirk Avenue, Brooklyn.
J. F. Haller, 291 Stuyvesant Avenue, Brooklyn.
I. McMunn Holly, 636 St. Marks Avenue, Brooklyn.
George R. Hawley, 309 Gates Avenue, Brooklyn.
Charles J. Search, 168 Putnam Avenue, Brooklyn.
Gordon R. Hall, 164 Clinton Street, Brooklyn.
Harold F. Jewett, 1072 Bergen Street, Brooklyn.
B. F. Knause, 1076 Bushwick Avenue, Brooklyn.
J. J. Lamadrid, 412 Greene Avenue, Brooklyn.
Walter D. Ludlum, 362 East 15th Street, Brooklyn.
Joseph Mezrbach, 198 Eighth Avenue, Brooklyn.
T. H. Northridge, 320 Cumberland Street, Brooklyn.
Burr B. Mosher, 44 Court Street, Brooklyn.
Edward L. Oatman, 82 Remsen Street, Brooklyn.
Walter D. Price, 202 Schermerhorn Street, Brooklyn.
J. Randolph Quinn, 314 Greene Avenue, Brooklyn.
Nathaniel P. Rathbun, 240 Greene Avenue, Brooklyn.
Henry N. Read, 228 Clinton Street, Brooklyn.
C. T. Sauer, 284 Sixth Avenue, Brooklyn.
John M. Taylor, 438 Third Street, Brooklyn.
James Y. Tuthill, 100 Fort Greene Place, Brooklyn.
George Wackerhagen, 28 Seventh Avenue, Brooklyn.
F. W. Wunderlich, 165 Remsen Street, Brooklyn.
J. S. Waterman, 676 St. Marks Avenue, Brooklyn.
M. F. DeLorme, 344 Jay Street, Brooklyn.
John G. Dickert, 928 Bushwick Avenue, Brooklyn.
Raymond Clark, 310 Clinton Avenue, Brooklyn.
Edward F. Lindridge, 424 Vanderbilt Avenue, Brooklyn.
George Drury, 235 Washington Avenue, Brooklyn.
Charles L. Fincke, 166 Clinton Street, Brooklyn.
Charles F . Buckley, 802 Carroll Street, Brooklyn.
J. S. Wight, 30 Schermerhorn Street, Brooklyn.
Henry D. White, 206 Garfield Place, Brooklyn.
William Boes, 200 Graham Avenue, Brooklyn.
William J. Cruikshank, 102 Fort Greene Place, Brooklyn.
E. W. Skelton, 296 Sixth Avenue, Brooklyn.
Dudley D. Roberts, 84 Remsen Street, Brooklyn.
Arnold W. Catlin, 207 Greene Avenue, Brooklyn.

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George T. Wetmore, 422 Clermont Avenue, Brooklyn.
Lawrence J. Morton, 303 Henry Street, Brooklyn.
H. A. McChesney, 90 Halsey Street, Brooklyn.
George D. Hamlin, 1260 Pacific Street, Brooklyn.
Peter A. Keil, 170 Barbey Street, Brooklyn.
George H. Cruikshank, 140 Sixth Avenue, Brooklyn.
Lewis G. Langstaff, 175 Sixth Avenue, Brooklyn.
Ralph C. Williams, 515 47th Street, Brooklyn.
H. A. Wade, 495 Greene Avenue, Brooklyn.
P. V. Costello, 366 Herkimer Street, Brooklyn.
Stephen L. Taylor, 644 St. Marks Avenue, Brooklyn.
Thurston H. Dexter, 411 Hancock Street, Brooklyn.
Lewis W. Anderson, 513 Bedford Avenue, Brooklyn.
Cecil MacCoy, 151 Clinton Street, Brooklyn.
Edwin H. Fiske, 127 Lafayette Avenue, Brooklyn.
Joseph P. Sheridan, 36 Johnson Avenue, Morris Park, L. I.
James E. Burns, Glen Cove, L. I.
Barton W. Brush, Woodside, L. I.
George Forbes, 710 Vernon Avenue, Long Island City.
J. M. Foster, Valley Stream, L. I.
Harris A. Houghton, Bayside, L. I.
Joseph F. Gray, 10 W. Hammels Av., Rockaway Beach, L.I.
L. Howard Mass, Elm St. & Orchard Av., Richmond Hill.
Henry M. Warner, Hempstead, L. I.
Guy H. Turrell, Smithtown Branch, L. I.
George H. Downey, Great Neck, L. I.
Henry F. Owsley, 259 Amity Street, Flushing, L. I.
Lawrence Coffin, Bay Shore, L. I.
Convas L. Markham, Amityville, L. I.
Frank C. Dildine, Port Jefferson, L. I.
A. J. Rosanoff, Kings Park State Hospital, L. I.
Benj. F. Rogers, Eastport, L. I.
Theodore W. Simon, Kings Park, L. I.
A. J. Capron, Kings Park, L. I.
Albert Ullman, Kings Park, L. I.
L. C. Baldwin, Bellport, L. I.
Herman G. Wahlig, Sea Cliff, L. I.
Patrick McKeown, 141 Third Street, Long Island City.
Henry J. McKenna, 113 Fifth Street, Long Island City.
Enoch P. Lawrence, Amityville, L. I.

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The following gentlemen were elected to Honorary Membership:

George Henry Fox, M.D., of New York.
Leonard Wood, M.D., Major General, United States Army.
Theodore Roosevelt, President of the United States.

The resignation of Dr. C. W. Walling, of Bellport, was received and accepted.

The Secretary reported that at a meeting of the Ex-Presidents and Board of Directors, on May 14, in Brooklyn, Dr. J. M. Winfield was appointed a committee to confer with the PHYSICIANS MUTUAL AID SOCIETY, the object being to insure members from THE ASSOCIATED PHYSICIANS OF LONG ISLAND.

At the same meeting, Dr. Ross was appointed a committee to investigate insurance against suits for malpractice.

The action of the Board of Directors in the matters referred to, was approved by vote of the Association.

The following communication from the Board of Trustees was presented:

WHEREAS, a movement has been inaugurated by the Hon. Edward M. Grout, Comptroller of the City of New York, looking to the establishment of a public university in the Borough of Brooklyn; and

WHEREAS, The Associated Physicians of Long Island have been given representation on the committee of citizens appointed for furthering the project, and asked to co-operate and assist in promoting it; therefore be it

RESOLVED, That the Board of Trustees of The Associated Physicians of Long Island is in hearty accord with the proposition to establish such a university in Brooklyn, and recommends that The Associated Physicians of Long Island endorse the proposition, and pledge to the Hon. Edward M. Grout their active support and co-operation in securing such an educational institution.

The Association by vote endorsed the action of the Board of Trustees.

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SCIENTIFIC SESSION.

Dr. Robert L. Dickinson, Chairman.

PAPER.

"Cure of Carcinoma of the Breast." Dr. Lewis S. Pilcher, Brooklyn.

Discussed by Drs. H. B. Delatour, S. C. Blaisdell, J. S. Wight, M. Figueira. Closed by writer.

PAPER.

"The Surgery of Dyspepsia." Dr. Richard W. Westbrook, Brooklyn.

Discussed by Henry A. Fairbairn. Closed by writer.

JAMES COLE HANCOCK,
Secretary.

Twenty-third Regular Meeting, held at Centre Moriches, L. I., October 21, 1905.

The President, Dr. William B. Savage, in the chair.

The meeting was called to order, and the minutes of the previous meeting read and approved.

REPORT OF MEMBERSHIP COMMITTEE.

The Membership Committee reported favorably upon the following applications for membership, and they were elected to membership:

Thomas B. Spence, 139 Seventh Avenue, Brooklyn.
Homer E. Fraser, 18 S. Portland Avenue, Brooklyn.
Richard C. Brewster, 126 Lefferts Place, Brooklyn.
Frederick Tilney, 47 Pierrepont Street, Brooklyn.
Frederick C. Holden, 63 Seventh Avenue, Brooklyn.
James J. Terhune, 169 Adelphi Street, Brooklyn.
Martin Amador, 187 Park Avenue, Brooklyn.
Charles Bellows, 433 Nostrand Avenue, Brooklyn.
William F. Swalm, 118 Lafayette Avenue, Brooklyn.
John A. Longmore, 26 Schermerhorn Street, Brooklyn.
Christopher D. Kevin, 719 Halsey Street, Brooklyn.
Roger Durham, 671 Vanderbilt Avenue, Brooklyn.
John J. Carey, 287 Hoyt Street, Brooklyn.

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J. Wheeler Smith, 1120 Herkimer Street, Brooklyn.
George W. Simrell, 190 Clarkson Street, Brooklyn.
Charles P. Frishbier, 865 Halsey Street, Brooklyn.
Harold Bryn, 313 Sackett Street, Brooklyn.
J. Glen Allen, 141 Noble Street, Brooklyn.
A. Walter Durand, Brentwood, L. I.
M. M. Slocum, 25 Mott Avenue, Long Island City.
Frederick W. Fletcher, Freeport, L. I.
J. M. Hartranft, Southold, L. I.
John B. Welwood, Wantagh, L. I.
Clarence E. Whitney, State Hospital, Central Islip, L. I.
Clarence L. Vaux, State Hospital, Central Islip, L. I.
F. Hinckley, State Hospital, Central Islip, L. I.
Calvin B. West, State Hospital, Central Islip, L. I.

SCIENTIFIC SESSION.

Dr. Robert L. Dickinson, Chairman.

PAPER.

"Conservative Treatment of Urethral Stricture." Dr. G. M. Muren, Brooklyn.

Discussed by Drs. Overton, DeForest, Sullivan, Maddren, and Dickinson. Closed by the writer.

PAPER.

"More Rapid Correction of Lateral Curvature of the Spine." Dr. Walter Truslow, Brooklyn.

Discussed by Drs. Savage, Bartley, Sullivan, Delatour, and Maddren. Closed by the writer.

Adjourned.

JAMES COLE HANCOCK,
Secretary.

Eighth Annual Meeting (Twenty-fourth Stated Meeting), held in the Library Building of the Medical Society of the County of Kings, Brooklyn, N. Y., January 27, 1906.

The President, Dr. William B. Savage, in the chair.

The meeting was called to order, and the minutes of the previous meeting and the last annual meeting were read and approved.

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REPORT OF MEMBERSHIP COMMITTEE.

The Membership Committee reported favorably upon the following applications, and they were elected to membership:

S. F. Anderson, 765 Union Street, Brooklyn.
Charles A. Lubrecht, 966 Bedford Avenue, Brooklyn.
Edward J. McEntee, 93 Lee Avenue, Brooklyn.
Edward F. Marsh, 448 Ninth Street, Brooklyn.
Robert T. Wheeler, 209 Hewes Street, Brooklyn.
Victor H. Pentlarge, 198 Eighth Avenue, Brooklyn.
A. W. Jagger, 410 Amity Street, Flushing, L. I.
John D. Brundage, West Hampton Beach, L. I.
Calvin B. West, Central Islip, L. I.
Frederick C. Peterson, Smithtown, L. I.
J. Ferdinand Bates, Setauket, L. I.
James A. Squires, Stony Brook, L. I.

REPORT OF THE SECRETARY.

Mr. President: Your secretary has to report that during the past year there has been even more than the usual progress made in the Society's affairs. The meeting of July 12, held at Oyster Bay, attracted the largest attendance in the history of the Society. President Roosevelt made an interesting address, and was later made an Honorary Member; as were also Major General Leonard Wood and Dr. George Henry Fox, of New York.

The meeting at Centre Moriches, October 21, was well attended.

There have been, during the year, five deaths and one resignation.

The total membership, at the present time, is 483. Of this number, 477 are active members, and six are honorary. Of the 477 active members, 146 are from Queens, Nassau and Suffolk Counties and 331 from Kings.

The Long Island Railroad has extended the usual appreciated courtesies.

JAMES COLE HANCOCK,
Secretary.

The report of the Secretary was filed as read.

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REPORT OF THE TREASURER.

RECEIPTS.

Balance on hand, January 28, 1905,.....	$248.30
Received from dues,.....	667.50
Received from dinners,.....	452.50
	$1,368.30

DISBURSEMENTS.

Total disbursements,.....	$1,278.03
Balance on hand, January 27, 1906,..	$90.27

Respectfully submitted,

C. B. Bacon,
Treasurer.

The accounts of the Treasurer were received and referred to an Auditing Committee which later reported that they were correct.

REPORTS OF COMMITTEES.

REPORT OF HISTORICAL COMMITTEE.

The Chairman of the Historical Committee reported the following deaths during the year:

Henry Cornelius McLean, A.M., M.D., member 1899-1904: died December 23, 1904.

Homer Lyman Bartlett, M.D., member 1899-1905: died February 3, 1905.

Richard Henry Sullivan, M.D., member 1903-1905: died March 27, 1905.

Heber Nelson Hoople, A.B., M.D., member 1899-1905: died May 8, 1905.

Ezra Herbert Wilson, M.D., member 1898-1905: died December 19, 1905.

H. H. Young, M.D., Riverhead, member 1902-1905: died January 16, 1906.

George T. Fanning, Smithtown Branch, member 1903-1905: died July 5, 1905.

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Dr. Winfield read the following report of the committee appointed to look into the matter of life insurance and relief fund for the widows and orphans of members of the Association. The report was accepted and ordered filed.

Mr. President: According to your recommendation made in your inaugural address, your committee has looked into the matter of establishing an aid association, life insurance, and a relief fund for the widows and orphans of members of the Associated Physicians of Long Island.

To establish anything like a mutual benefit life association it would necessarily have to be done under the laws of the State of New York, and consequently under the supervision of the Superintendent of Insurance. It would require some capital to start, it might not always be upon a very sound financial foundation, it would require considerable business detail, and it would also be necessary to have a distinct set of officers to carry on its business.

Another point in your address which is of specal interest to us all is the establishment of a relief fund for the widows and orphans.

There is in existence an organization known as "The New New York Society for the Relief of Widows and Orphans of Medical Men." While this is on a sound financial basis and is managed by careful men, it seems to your committee that the cost is more than most of our members would care to assume, especially as the benefits are comparatively small. The initiation fee is twenty-five dollars with ten dollars annual dues; for a life membership, one hundred dollars. The maximum annuity to the widow is between four and five hundred dollars, subject to certain regulations. The orphan receives one hundred dollars annuity.

After considering the various plans proposed and looking into the already established benefit associations, your committee thinks that for an insurance the cheapest and easiest plan would be for as many members as possible to join the New York Mutual Aid Association, the assessments of which amount to about fifteen dollars a year. The beneficiary receives $1,000.00. To arrange for an orphan relief fund it might be a good plan to have a permanent committee elected, to be known as the Relief Committee of the Associated Physicians of Long Island. As the By-Laws will not permit of electing this committee at this meet-

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ing, I move, sir, that the President appoint a committee of three to arrange the matter, and to report at the June meeting. It would be best to have each County on the Island represented.

J. M. WINFIELD.

Drs. Winfield, Browning and Ross were appointed a committee to arrange the details of the benefit fund suggested by the report as read.

The President appointed Drs. Lanehart, Van Cott and Morrison as a Nominating Committee.

Dr. Ross reported, on behalf of the committee appointed to take up the matter of indemnity or defense insurance, that the members of the Suffolk County Society wished the matter to be allowed to rest with the State Society.

ANNUAL ELECTION OF OFFICERS.

The Nominating Committee reported the following nominations:

President, Elias H. Bartley; First Vice-President, J. Ensor Hutcheson; Second Vice-President, H. B. Delatour; Third Vice-President, Arthur H. Terry; Secretary, James Cole Hancock; Treasurer, Charles B. Bacon.

The Secretary was empowered to cast the ballot of the Association for the gentlemen named, and they were declared elected.

SCIENTIFIC SESSION.

Dr. Robert L. Dickinson, Chairman.

PAPER.

"The Surgery of the Kidney:" With Lantern Slide Demonstrations. By Howard A. Kelly, M.D., Baltimore, Md.

On motion of the Association a vote of thanks was tendered to Dr. Kelly for his courtesy in addressing the members of the Association, and for his very interesting paper.

Adjourned.

JAMES COLE HANCOCK,
Secretary.

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ADDRESSES.

INAUGURAL ADDRESS.

DR. WILLIAM BESLEY SAVAGE,
EAST ISLIP, L. I.

GENTLEMEN:

A brief review of the past of our association may not be out of place at this time. We have already entered upon the eighth year of our existence with a membership of 365, which membership I can assure you will be materially increased during the present year.

An association, unique and distinct in many ways from any medical organization on this, "The Pearl of the Atlantic;" unique, in as much as it contains less factionalism than is usual in medical coalitions and that its members can meet and learn to know each other quicker owing to its social side, and that, endemic as we are, our Association can and does become sporadically epidemic by virtue of its meetings held in the Summer and Fall.

This Association has been the means, and the only means, of bringing the general Island practitioner into touch with his city brother and it is urgently desired that the hidden glories of the Borough of Brooklyn, both medical and surgical, may be better known to those outside of it by a greater attendance at our meetings, a fostering of strictly ethical conditions and a due ignoring of anything savoring of factionalism.

There has been some question as to what the future status of this Association will be when the State Society is redistricted, and it has been assumed, unwarrantably I think, that we might possibly lose in a measure, our individual identity as an association. This, I believe, is a fallacy, for we are strictly healthy, not of the annual variety, and believe in knowing each other much better than we could by yearly visits; and the spirit by which we were begotten holds as firmly to-day as it did eight years ago. And if I misjudge not, our existence is in no danger.

There is need, and pressing need, for closer organization, and one of the ways in which this can be accomplished is in making this Association appeal to each member and at the same time

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increase its distinctiveness, and to this end I would suggest that there be established a fund to be known as the Mutual Protective Fund, to have for its object the inculcating of greater respect for the medical profession by decreasing the desire of individuals to mulct any of its members by unjust suits for malpractice, to stand behind its members through its legal representatives and accord not only moral but material support when an innocent member is maliciously threatened by suit for malpractice. Such a fund to be started and maintained by making a per capita assessment permissible, and to be further augmented by a setting apart of a portion of any surplus at our annual meetings, such per cent. of surplus to be determined by the Trustees of the Association or by changing or adding to the By-Laws, as you may determine.

I would also impress upon you that this Association is admirably organized to hold or handle funds or endowments for the benefit of disabled practitioners of the Island or needy families of physicians, or for any common purpose. In this connection it seems to me that a permanent Committee might be established to be known as the Relief Committee of the Association whose purpose would be to find suitable employment for members of needy physicians' families, where any of them had ability to do something. Most of us know that such cases at times occur, and for lack of organized effort little is done to procure permanent relief.

So, too, there is a field upon this Island that has not as yet been thoroughly gleaned by your Historical Committee. I refer, for instance, to the Huntington family of doctors, formerly of Easthampton, which are well worthy of a historical sketch, and other material which if brought to the notice of your Committee would no doubt receive its attention.

We can also become a closer organization did we take up from time to time the discussion as an association of legislative matters which directly affect the profession and give united support or discountenance, as the case warranted, and thus aid our legislators by unity of action of our large membership. In my opinion it would carry greater weight than individual appeal, as is usually done when pernicious bills are introduced in the State Legislature.

During the past seven years of our existence, let it be noted

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that we have tried with eminent success to maintain and retain our independence. This is vital to our continued success. We fill a place untouched by any other Island Society, as is attested by our increasing membership. Indirectly too, we have, by our fair-mindedness helped to revive and stimulate interest in the various County Societies, by making membership here coincident with membership in them; hence healthy growth and any lack of fealty to this Association would produce a corresponding stagnation in the County Societies. This is not the wail of an alarmist, but I am simply trying to show that a constant effort of loyalty and independence to our Association will help to keep up interest in those watchdogs of the medical profession—the County Societies—which are indispensable.

I congratulate you upon the increasing membership and most heartily thank the various Committees for their earnest work and co-operation, which if continued should and will prove beyond question the tenacity of our life as an association.

ADDRESS OF THEODORE ROOSEVELT,

PRESIDENT OF THE UNITED STATES.

Mr. President, Members of the Association, Friends and Neighbors: I needed no invitation to come before you to-day—all I needed was permission. As soon as I learned that this Association was to meet in our village, I felt that I must take advantage of the opportunity to say a word of greeting to you in person. Of course, it is almost needless to say that there is not and cannot be any other lay profession, the members of which occupy such a dual position, each side of which is of such importance, for the doctor has on the one hand to be the most thoroughly educated man in applied science that there is in the country, and on the other hand, as every layman knows, and as doubtless many a layman in the circle of acquaintances of each of you would gladly testify, the doctor gradually becomes the closest friend of more different people than would be possible in any other profession. The feeling that a man has toward the one human being to whom he turns either in time of sickness for himself or, what is far more important, in the time of sickness of those

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closest and dearest to him, his feeling for that man can not but be of a peculiar kind. He can not but have a feeling for him such as he has for no other man, and the doctor must therefore, to the last degree, develop his nature along the two sides of his duties, although in the case of any other man we would call him a very good citizen if he had only that one side. The man who is a first-class scientist has a claim upon the credit of all the country, and the man who is a first-class neighbor and is always called on in time of trouble by his neighbors has an equal claim upon society at large, but the doctor has both claims.

Yet in addition to fulfilling both of these functions, he may fill many other functions; he may have served in the Civil War, he may have rendered the greatest possible service to the community along in one of a dozen different lines. Take, for instance, just what is being done in one of the great works of this country at the present time—the digging of the Panama Canal. That is a work that only a big nation could undertake, or a big nation do, and it is a work for all mankind. A condition precedent upon success in that work is having the proper type of medical work as a preliminary—as a basis. That is the first condition, upon the meeting of which must depend our success in solving the engineering and administrative problems of the work itself, and I am happy to say that the work is being admirably done. I want to say this particularly; I am glad to have this chance of saying it, because you will now and then see alarmist reports from Panama.

A couple of weeks ago there seemed to be a succession of people who came up from Panama, each one of whom had some tale of terror to tell. Now you will always find in a battle, even if it is a victorious battle, that in the rear you meet a number of gentlemen who are glad that they are not at the front, who if they have unfortunately gotten at the front, have come away, and who justify their absence from the front by telling tales of how everything has gone wrong. Now the people who flee from Panama will carry up here just such stories as the people who flee from the forefront of a battle carry to the rear with them, and the people to whom this country owes and will owe so much are those who stay down there and do not talk, but do their work and do it well.

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Now, of course, in digging a great work like that and in the tropics, in a region which, until this Government took hold of it, was accounted to be a region exceptionally unhealthy, we are going to have trouble. We will have some yellow fever, we will have a good deal of malarial fever and suffer more from that than the yellow fever, although we will hear nothing like the talk about it. We will have every now and then troubles as regards hygiene, just as we will have troubles in the engineering work, just as we will occasionally have troubles in the administrative work, and whenever any one of these troubles occurs, there will be a large number of excellent but timid men, of little faith, who will at once say that it is an awful calamity, and express the deepest sorrow and incline to the belief that the whole thing is a failure. It will not be a failure. It will be a success, and it will be a success because we shall treat every little check, not as a reason for abandoning the work, but as a reason for altering and bettering our plans, so as to make it impossible that that particular check shall happen again.

Gentlemen, what is being done in Panama is but a sample of the things that this country has done during the last few years—of the things in which your profession has borne so prominent a part. Take what we did in Cuba; we tried the experiment which had not been tried for four hundred years, of cleaning the cities. One of the most important items of the work done by our Government in Cuba was the work of hygiene, the work of cleansing and disinfecting the cities, so as to minimize the chance for yellow fever, so as to do away with as many as possible of the conditions that told for disease. I do not say you can eradicate disease entirely, any more than you are ever going to get men entirely virtuous, but we can tend in that direction, and this country has never had done for it better work, work that reflected more honor on the country, that was of more benefit to humanity at large than the work done for it in Cuba, and the man who, above all others, was responsible for doing that work so well was a member of your profession, who in the call to arms came himself, as a soldier, to the field, the present Major General Leonard Wood. Leonard Wood did in Cuba just the kind of work that, for instance, Lord Cromer has done in Egypt. We have not been able to reward Wood in anything like the proportion that services such as his would have been rewarded in any

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other country of the first rank in the world, and there has been no meaner or more unpleasant manifestation in all our political history than the feeling of envy and jealousy manifested toward Wood, and the foul assaults and attacks made upon him were largely because they grudged the fact that this admirable military officer should have been a doctor.

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SCIENTIFIC TRANSACTIONS

OF THE

ASSOCIATED PHYSICIANS OF LONG ISLAND.

THE CURE OF CARCINOMA OF THE BREAST.

By LEWIS STEPHEN PILCHER, M.D., LL.D.,
OF BROOKLYN,
Surgeon to the Methodist Episcopal and to the German Hospitals in Brooklyn.

Breast carcinoma presents a very favorable field for the study of therapeutic possibilities. The disease in this location is of frequent occurrence; the tissue primarily affected is deep-lying but at the same time as susceptible by palpation and vision to as constant and accurate knowledge of its progress as if it was absolutely superficial; the lymphatic channels which lead from it are definite and well understood, and the lymph nodes in which occur the first metastatic developments are equally as accessible to operation, as the gland containing the parent growth. Concealment or error as to the real conditions present in a given case is therefore impossible. Unlike carcinoma involving the digestive or urinary tract, its cause is not complicated by the irritation of continued function nor by the results of impaired function. The feebler malignancy of the superficial carcinomata developing from epithelium of the squamous type is unfortunately not shared by breast carcinomata, which in their tendency to rapidity of growth, to invasion of adjacent tissues and to the formation of metastases are typical of the most virulent forms of the disease in any part of the body.

On the other hand, the breast lends itself with less disadvantage than any other part of the body to absolute extirpation, and the possibility of extending surgical attack to adjacent tissues and of following to a great distance the lymph vessels and nodes without inflicting serious damage to function or incurring serious risk to life is such as to make available the highest degree of

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thoroughness in operative attempts to remove the disease and to secure permanent immunity from further growth.

In carcinoma of the breast, therefore, we possess an ideal test type of the disease, carcinoma, by which to measure the efficiency of methods and agents that may be proposed for its treatment. For this reason breast carcinoma still retains a special interest and I have determined to bring it up for discussion again at this time.

In a paper published by me in 1902, I analyzed the results obtained by operative attempts in fifty personally treated cases of primary breast carcinoma, and one of my conclusions then stated was that surgery could promise a very large proportion of absolute cures in such cases if its resources were employed as soon as the presence of the disease is determined.

Out of forty-three patients in whom a presumably complete operation was done, thirteen presented the least advanced type of the disease, viz., that in which no involvement of the pectoral muscles was apparent, and the involvement of the glands of the axilla was not great. In these cases ablation of breast and axillary contents and of the pectoralis major muscle (except in two cases in which this muscle was not removed) resulted in permanent cure in four instances—eleven to thirteen years having now elapsed.

In twelve other patients the involvement of the pectoral muscle or the invasion of the axilla was so much more pronounced that it was deemed best to remove the pectoralis minor muscle also, but without attacking the supraclavicular spaces.

Permanent cure resulted in four of these patients also. In my former report I credited this group with but three permanent cures. In one of the remaining patients there had developed an intra-abdominal disease which I then supposed to be carcinoma of the liver. More careful examination later, after the greatly distended abdomen had been emptied by tapping, revealed that the condition was ovarian, and by opening the abdomen a large, benign, multilocular cystadenoma of the ovary was removed, with subsequent perfect health to date, so that I can now make this more favorable report. In all but one of the eight patients of this class who were not permanently freed from carcinoma by my operations the development of supraclavicular disease was among the earliest evidences that the primary operation had been incomplete. Impressed by this I was led to open up the supra-

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clavicular spaces in many instances thereafter, notwithstanding the absence of evident supraclavicular disease, and in nearly all such cases this incision above the clavicle revealed small nodules distinctly cancerous, though too minute to be detected by palpation when covered by intact fascia and skin. The entire number of cases in which the supraclavicular spaces were thus opened was eighteen, in ten of whom palpable supraclavicular nodes existed. Permanent cure has followed in three of these cases as demonstrated by nine, seven and five years, respectively, of freedom from recurrence. This also is one more case of cure than I claimed three years ago, due to the fact that a case in which a perceptible enlargement over the upper costo-chondral articulation of the affected side, which was considered then as due to recurrence of the carcinoma, has since been demonstrated to have have been due solely to hypertrophy of the clavicular portion of the pectoralis major muscle that had been left unremoved. The woman has remained well to the present date, now more than five years since operation.

This, then, was my record up to the year 1900. Previous to 1888 no permanent cures; from 1888 to 1900, 25 per cent. permanent cures.

During the years 1901 to 1904, sixteen more primary cases have been operated upon. Of these, in three instances the operation was frankly incomplete and was followed by speedy recurrence, except in one case which died on the table after an interscapulo-thoracic amputation.

Of the thirteen cases in which an apparently complete operation was done, five of them, at periods of from six months to two years, showed either regional or distant metastatic growths that had escaped the knife; all of these were systematically and for long periods subjected to X-ray treatment, with apparent retardation of the superficial growths in each case, but without effect upon the development of intra-thoracic or intra-abdominal metastases that terminated in death in from one to three years after operation.

Seven cases—54 per cent.—remained well when last heard from. What proportion of these may yet present recurrences time only can show.

Of this series of cases, in all but two the region above the clavicle was opened and all the gland and lymph vessel bearing connective tissue beneath the deep fascia in the subclavian triangle

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dissected out systematically. In the majority of instances, small but distinctly cancerous nodes, not appreciable through the skin and fascia, were brought to light by this incision and were removed.

Let me cite two instances.

CASE I. F. M. C., aged 53 years, whose grandmother, two great-aunts, one aunt and one cousin had all died of cancer—grandmother, cancer of rectum; others, cancer of breast—presented herself with an ill-defined induration of moderate extent in the left breast under the nipple. There were no palpable glands either in the axilla or in the supraclavicular space. Within three weeks of the time that the breast change was first detected, operation was instituted. The first operative step was the opening of the supraclavicular space at once. In the angle formed by the junction of the internal jugular and subclavian veins two small cancerous nodes were uncovered. In the axilla, also, when opened in a later step of the work, multiple affected nodes were found. The entire operation included cleaning out the supraclavicular space; cleaning out the axilla; detachment at insertion of both pectoral muscles and their removal with the overlying breast and a like amount of the covering skin.

An uncomplicated convalescence followed. At present date, sixteen months later, there is no suggestion of recurrence and she remains perfectly well.

CASE II. M. M. A., aged 66 years; presented herself with an ovoid mass infiltrating the upper outer quadrant of the right breast, the presence of which had been known for four months. The overlying skin had become adherent but there were no enlarged glands palpable either in axilla or above the clavicle. Nevertheless the supraclavicular and axillary incisions revealed conditions nearly identical with those in the preceding case, just described. The same operative procedure was adopted, an equally uneventful and rapid convalescence followed. She presented herself recently for examination, eight months later, local and general conditions perfect.

These two case are good examples of the most favorable cases for surgical effort that present themselves to the surgeon. They both came to operation at a fairly early period of the carcinomatous process. There were no evidences of supraclavicular involvement, and yet if this region had not been opened as a matter of routine, diseased nodes would have been left behind

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to ensure a perpetuation and extension of the carcinoma, and to make of no avail the extirpation of the breast.

A somewhat different but equally striking lesson was conveyed by the following case:

CASE III. S. M. B., aged 59 years; had been aware of the presence of disease in her right breast for eighteen months, but had concealed it even from her physician. When she finally presented herself for surgical aid there was a diffuse induration having its centre in the outer and lower quadrant of the breast; overlying skin adherent; nipple retracted; enlarged axillary glands palpable; no positive involvement of supraclavicular glands demonstrable. At operation axillary contents, pectoral muscles, breast and underlying skin were first removed. The extension of the disease to the nodes above the clavicle was demonstrated at this time, but it was not deemed prudent to continue the operation at that time and the wounds were closed. Five weeks later, full healing of the axillary and thoracic wounds having been secured, the base of the neck was opened, the clavicle was sawn through on either side of the insertion of the subclavius muscle, and the bone-muscle flap thus formed turned down, exposing the entire area from the point where the axillary clearing out had ceased, to the point where the great vessels at the root of the neck descend into the mediastinum. Multiple infected glands were found in this region and were removed. The convalescence from this assault, otherwise favorable, was complicated by a limited necrosis from the isolated bone section. This determined a sinus, which persisted for some weeks until a necrotic splinter was exfoliated, and together with a wire suture, was discharged. Sound healing then took place. Good health without sign of recurrence finally resulted and has been maintained to date, a period of two and a half years.

The added experience of the last three years has corroborated the views expressed by me in 1902 as to the importance of opening the base of the neck as a part of the routine operative procedures in cases of breast carcinoma. The point of suspicion, the key to the whole situation, is the triangle at the junction of the subclavian and internal jugular veins, where rest the node or nodes to which run not only the lymphatics which pass up from the axilla, but also an inconstant but not infrequent set of ducts which run up on the front of the thorax from the mammary region to the base of the neck, down into which they dip after

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running over the inner end of the clavicle. The exposure of this space, while certainly a delicate procedure and requiring accurate anatomical knowledge, is neither difficult, nor unduly time-consuming, nor disfiguring. It adds but little to the gravity of the operation as a whole, least of all if no infected nodes are found that require removal, while if such diseased foci are found any added risk is more than justified. It is in the cases that come earliest to operation, also, that such investigation of the base of the neck offers the greatest advantage, for these are the cases that present the most hopeful field to a surgical attempt to get beyond all foci of disease in the work of extirpation. The life history of all deep-lying carcinoma involves so early in its course the lymphatic paths that extend from the regions involved that these must always rest under suspicion, however apparently early the primary growth may have been recognized, and the rational procedure is to always include in the extirpations done all such absorbent organs as far as possible without waiting for the development in them of gross evidences of disease. Just in measure as this practice has become adopted in the surgery of breast carcinoma have the results obtained been more and more favorable as regards permanent cure. The steps have been, consecutively, the removal of the fascia covering the pectoral muscles, the systematic and thorough évidement of the axilla, the removal of the pectoral muscles, the increase in the amount of overlying skin removed. Add to these now, as a part of the regular procedure of attack, to be omitted only in exceptional cases in which adequate reason for the omission may satisfy the surgeon that it is best, the systematic évidement of the subclavian triangle, and there may be expected a still higher percentage of permanent cures.

The use of the X-ray in breast carcinoma has not been attended with any lasting benefit in the cases that have been under my observation, notwithstanding all the cases of recurrence observed during the past five years have been given the benefit of its application, made intelligently and perseveringly. Whatever its advantage in the case of superficial epidermoid cancers, it has no place in the surgery of cancer of the breast.

DISCUSSION.

DR. H. BEECKMAN DELATOUR said that his experience with the X-ray in the treatment of these cases had been in a direct

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line with the results Dr. Pilcher had had. He had yet to see a case benefited by the most persistent and careful administration of the X-ray.

Further in those cases treated by the X-ray, after they once begin to advance, it seemed to him in a large proportion of the late cases a more rapid growth followed than without that treatment.

To his mind there was an unquestionable increase in the number of cases of carcinoma of the breast. He was sure that within the last six months he had seen more cases and operated on more cases of carcinoma of the breast than he had in any previous eighteen months, and he was also sorry to say that these cases came no earlier than they did formerly. No matter how thorough and complete an operation we may make or desire to make, the state of the disease must have a large influence in the cure. The simple removal of the breast as an operative procedure is now a thing of the past, except possibly such cases as are in such bad condition that complete and thorough extirpation is out of the question, and where we have a sloughing mass which is disagreeable to the patient and her friends, which can be removed and thus give some relief in that direction. The speaker said we must go to the full extent, if possible, if we are going to look for good results. The added incision and clearing out the glands above the clavicle, as suggested by Dr. Pilcher, was, to his mind, one of the greatest advances in this class of operative procedures. It had been his misfortune in a number of instances to have recurrences take place, or, more properly speaking, continual growth take place in the glands above the clavicle and in the mediastinal glands, where simply the breast and axillary contents were removed. It is probable that the infection may only have been in the supraclavicular glands at the time, and that the mediastinal glands were secondarily infected. He felt that in those cases if he had followed out the plan of the complete removal of the glands above the clavicle with the breast that the result might have been different.

With the complete and thorough removal, as detailed by Dr. Pilcher, and particularly if we can get cases at a little earlier stage than we have been getting them, we will see a very decided improvement in the final results. He thought we ought to impress on medical men generally that the mortality after operations in cases of carcinoma of the breast, even as extensive operations as

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had been proposed, is almost nil. It is a rare thing to have a patient die directly or even indirectly from the operation itself.

DR. S. C. BLAISDELL said that as regards Dr. Pilcher's paper he certainly could find no fault. As to opening the supraclavicular space in carcinoma of the breast where there is no apparent involvement of those glands, he inclined to the belief that it was wise never to kick a sleeping dog. If there is no trouble above the clavicle, do not touch it.

The speaker had had very bad results after the use of the X-ray in these cases. It seemed to make the disease progress faster.

DR. J. S. WIGHT believed that while we are applying and have been applying the science of electricity to the alleviation and cure of this condition, there are some facts which it is important to study in order to appreciate the results we have obtained. First it is safest to assume for the process of normal cell division and development that a certain physiological condition of equilibrium biogenesis has to be maintained. As to the effects of the X-rays, they retard osmosis, destroy the embryonal cells and disturb this biogenic equilibrium. They cause subcutaneous hemorrhages and telangectases. As to the results, the rays increase and stimulate the growth of the cells, undermine the cells, and in some cases relieve pain due to superficial ulceration. In superficial cases they retard the growth for a time only, and they do this through the osmotic effect that he had spoken of. They do it partly through the destruction of the embryonal cells, but their effect is not lasting.

In conclusion he would say that no primary case ought to escape the knife, and that no attempt should be made to treat a recurring case or an advanced case by the X-rays.

There are other agents that will bring about the same effect in these superficial cases that the X-ray will and as well. Liquid air, acid nitrate of mercury, and 3 per cent. nitric acid with petroleum jelly.

DR. M. FIGUEIRA agreed with Dr. Pilcher as to the necessity of thorough and complete removal of the glands in these cases of carcinoma of the breast, but in regard to entering the supraclavicular space, those who have seen much of cancer of the breast and its recurrences probably remember that recurrence

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in the supraclavicular space is the exception rather than the rule. Bryant, of London, says that 80 per cent. of recurrences take place in the axillary space, the other 20 per cent. being divided among the other regions of the body, the liver, spleen, etc. He says in his report that the recurrences which take place in 80 per cent. of the cases in the axilla take the following order: first, in the skin; second, in the fatty tissues; third, in whatever tissue may be left; and fourth, in the tissues around the breast, so that if the supraclavicular glands were so very important we should have in these statistics the 80 per cent. of recurrences in the supraclavicular instead of the axillary space. The speaker believed those who have seen much of this disease would bear him out in this contention.

In regard to treatment by the X-ray, he believed that there is a field for it as a preventive against a return of the disease after operation. He had followed this practice. Morton approves of it and he is a man of large experience. After a case has been operated on and has healed up and is doing well, he would subject it to the X-ray as a prevention against a return of the disease. The speaker thought in this way the X-ray serves a useful purpose.

DR. L. S. PILCHER, in conclusion, stated that he had a word or two to add. He appreciated highly the kindly manner in which the principles embodied in the paper had been received. He presented it not as a dogmatic affair, but as a suggestion for further observation and for further work in the war we are all waging with this most dreadful disease.

He was quite sure from an analysis of his own experience in that limited field at least it has been attended with a decided advance in the possibilities of securing a cure.

With regard to the statistics as to recurrences, which Dr. Figueira had just called attention to as given by Bryant, the speaker said it must be remembered that these statistics had to do with somewhat ancient history. In a period when the dealing with breast cancer was entirely different from what it is at the present time, operations were almost all incomplete, the axilla was not emptied, and, of course, the axilla and the immediate vicinity of the breast, the thoracic regions, were localities in which the already existing and not removed disease well advanced, declared themselves, and declared themselves with such

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rapidity and to such a degree that disease in the supraclavicular space was overlooked.

The speaker said he knew somewhat of Bryant's work, he knew somewhat of the English work generally, which was presented in these statistics, and he was quite sure that they were woefully incomplete as regards the perfection of the operations by the clearing out of the surrounding mammary and axillary spaces, and that they are not to be used by us at the present day as a basis upon which to form any judgment as to present practice. Let us, he said, have some more recent statistics in that respect. He had submitted simply the statistics which had come under his own observation, and he should distinctly reject from any collection, upon which any present deductions were to be based, any work which preceded the year 1895. He thought we might throw that all aside as, in a large proportion of the cases, incomplete and not to be used for our present conclusions. This is not saying anything against the ability of the English surgeons. They represented a certain point in the development of our work. We give them credit for it, and upon it the work of the present has been based, but we have gone beyond that now, and we must have different material upon which to form our present conclusions.

The experience of each man must, of course, determine his own personal work. We are all of us laboring to secure perfection in our work, and none of us, he believed, are tied to absolutism in anything. Wherever we can see any suggestion, which will bring to us a possibility of better work, certainly every one of us was anxious to secure it.

THE SURGERY OF "DYSPEPSIA."

By RICHARD WARD WESTBROOK, M. D.,

Attending Surgeon, Brooklyn Hospital.

The title of this paper may seem a trifle sensational, but I shall let it stand in order to emphasize the very important fact that the upper abdominal region is becoming more and more a field for surgical treatment, and less and less that for medical. It was but recently that this portion of the abdomen was considered almost entirely the territory of the physician, and the surgeon felt himself on unfamiliar ground when accident carried him

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above the level of the navel. All this is now rapidly changing, but there is yet great need for the studying anew of the upper abdomen and its relationships, especially on the part of the general practitioner. Inexact diagnoses are very common, and valuable time is being lost, and lives sacrificed, in endeavors to cure the so-called chronic dyspepsia, while the real lesion of gall-bladder, stomach, duodenum or pancreas is overlooked. And especially, I think, in our own section of the country are diagnoses of upper abdominal lesions badly made. The fact that no surgeon in the vicinity of New York can report any large series of operative cases in this field is good evidence that the profession in general here is not alive to the value of the operative treatment of these lesions. An unduly large proportion of our operations are upon late, complicated cases, or advanced cancerous conditions, and it is in the line of preventive therapeutics—by early operation upon uncomplicated conditions—that our best work must be done in this as in all lines of medicine. A recent observation of the work of some of the well-known surgeons of the West, has convinced me that they are much in advance of us in the solution of the problems of diagnosis and treatment in the upper abdomen. And from the large number of early cases coming into their hands for operation, it must follow that general practitioners and internists are not only able to differentiate the cases requiring surgical treatment, but are in accord with the surgeon as to the necessity of surgical intervention for cure. I was impressed with the fact, also, that even the laity in parts of the West make a better diagnosis and have a better appreciation of need for surgical treatment in upper abdominal diseases than many of our practitioners nearer home. Dr. A. J. Ochsner, of Chicago, whose work in upper abdominal diseases is so well known, told me that a considerable proportion of his operative cases came to him because of their knowledge of other similar cases which had been relieved by surgical treatment. Those of us who see much of appendicitis have repeatedly had the experience of the patient himself making his own diagnosis, when the pain localized in his right iliac fossa, and requesting surgical treatment. Appendicitis has some times been called a New York disease as much of its pathology and treatment were worked out in our midst. The physician and the surgeon are in accord as to its best treatment. The laity in their turn have been educated up to its importance, and to the necessity for its early surgical

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treatment. Not so the patient among us who is seized with pain above his belt. He thinks of acute indigestion, neuralgia of the stomach, ptomain poisoning, congestion of the liver, and a host of other things, and after the paroxysm is passed, resorts to shredded wheat and the various nostrums so widely advertised to physician and public. He knows little or nothing of gall-bladder disease or of ulcer of the stomach or duodenum. Continued dyspeptic symptoms, whether preceded by an acute attack, or originating gradually, have been for many decades ascribed to deficiencies in the digestive secretions of the stomach and intestines. "But," it has recently been said, "dyspepsia of the intractable, constantly recurring form, is more of a matter of physics than of chemistry." It is the peritoneal adhesions following inflammation of the gall-bladder and fixing it to the pylorus, which produce obstruction and dilatation of the stomach often, or the adhesions and distortions which follow ulcer of the duodenum or stomach that cripple the latter's action. Severe pain in the upper abdomen is often disregarded as having any surgical bearing, even though it may require doses of morphine of considerable size to allay it. Sharp abdominal pain is always to be carefully investigated, and if persistent and localized, always points to a lesion essentially surgical. Pain has been styled as "Nature's red flag of danger," never to be disregarded, nor its exact point of origin, if in the abdomen, left undetermined. The history of early pain is of the greatest value in making the later diagnosis in chronic conditions.

SOME ANATOMICAL CONSIDERATIONS.

As has been pointed out by Mayo, the confusion in diagnosis and treatment of upper abdominal disease has occurred because we have attempted to study the stomach independently of its associated organs, the liver and the bile passages, the duodenum, and the pancreas. A reference to our diagram will show in how close contact all these organs are with each other within a small area. The palm of the hand will cover them all in their most vulnerable portions. The stomach lies nearly vertically in the left hypochondrium and the epigastrium with its outlet—the pylorus—turned slightly upward to the right in the middle line of the body, the whole being somewhat pear-shaped. Continuous with this is four inches of much abused intestine,—the portion of duodenum lying between the pylorus and the opening

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of the bile and pancreatic ducts. Gall-bladder inflammation often results in adhesions to this portion of the duodenum which disturb its function and that of the stomach. The contents of the stomach mixed with the acid gastric juice are poured into the duodenum here, forming evidently the chief reason why ulcer of the duodenum occurs so much more frequently in this portion. The pouring out of the alkaline bile and pancreatic secretion below renders the remainder of the duodenum less liable to ulcer. Gall-stones or pancreatic stones lodged in the ducts will disturb the functions of the duodenum, and also of the stomach, with dyspeptic symptoms, the duodenum from the pylorus to the origin of these ducts being practically a part of the stomach. The shape of the duodenum, suggesting somewhat the trap of a drain-pipe with the first part of the ileum, and its large calibre, adapt it to the slowing of the food-current here, while the mixing with the secretions poured into it is going on.

It may be readily seen, then, that the intimate association of liver and bile-ducts, pancreas, stomach, duodenum, and even transverse colon, makes it of high importance to consider all of them in seeking the cause of intractable digestive disturbances. An inflammatory process originating in one of them may secondarily involve one or all the others.

It remains for us to determine what are the chief conditions demanding surgical relief in the upper abdomen, how we shall recognize them, and upon what grounds we may urge their surgical treatment as against medical treatment. W. J. Mayo says: "Eliminate chronic gastric ulcer, and the cases of chronic dyspepsia, gastralgia, and cardialgia not due to gall-stones or the appendix will be reduced to very small proportions." To these, I would add early gastric cancer. It is to the widespread but imperfectly recognized effects produced by gall-stones and gall-bladder disease, gastric ulcer, and duodenal ulcer that I wish to call your attention this afternoon; and also to the frequency with which early cancer of the stomach, *i. e.*, in the operable period, is allowed to masquerade under the diagnosis of dyspepsia. Chronic appendicitis as a cause of chronic indigestion, and its surgical treatment, are now well appreciated, but the full importance of the surgery of gall-stone disease and ulcer are hardly more appreciated among us now, than was that of the appendix fifteen years ago.

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GALL-STONE DISEASE.

Gall-stone disease is very common. Autopsies show that ten per cent. of all individuals have gall-stones. Kehr states that only five out of every hundred individuals having gall-stones ever have marked symptoms from them, and that the other ninety-five remain free from suffering. Gall-stones make symptoms only in the presence of active inflammation in the gall-bladder or ducts, and in the absence of inflammation remain quiescent or "latent." This statement of Kehr's that ninety-five per cent. of individuals having gall-stones have practically no symptoms from them has been widely quoted, and cases are often reported in which it is said that no sign of gall-stone disease was ever present until the onset of some extreme or even fatal attack. I am persuaded that this is all wrong, and that many of these cases suffer from the presence of gall-stones confined within the gall-bladder, and that their symptoms are rarely referred to the correct cause by the medical attendant in the absence of jaundice. These are supposed to be cases of dyspepsia, indigestion, gastralgia, gastric catarrh, etc., and the trouble is referred to the stomach. They suffer from flatulence and distention, and perhaps cramps, nausea and vomiting. To one accustomed to abdominal palpation, the diagnosis of these attacks is not difficult. Tenderness, in my experience, is invariably present, and pressure in the gall-bladder area beneath the right costal arch will elicit it. Frequently this tenderness is exactly at "Robson's point," which is as characteristic of gall-bladder inflammation as is "McBurney's point" of appendical inflammation, and should be as well known. This is almost invariably at the junction of the upper two-thirds with the lower third of a line drawn from the ninth rib to the umbilicus, or the tenderness may be all along this line or at any point of it, though at the point named it is the most frequent. Even when the gall-bladder is displaced from its usual position, this spot will generally be found tender on pressure. The pain may also extend around into the infrascapular region, and a tender point may not infrequently be found immediately to the right of the eleventh and twelfth dorsal spines in the back. Many cases of gall-stone disease are overlooked which have perfectly typical gall-stone colics, but of short duration and at long intervals apart. Although I do but a small proportion of medical work, I have seen incidentally quite a num-

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ber of acute attacks of short duration, which would pass for ordinary colic if not closely observed, but which were typical gall-stone colics. I was called to see the brother of a medical friend of mine, the latter being out of the city, and found that the patient had been seized a half hour previously with severe paroxysmal pain in the pit of his stomach. He was lying on his side, with anxious expression, knees drawn up, and the perspiration rolling off his face in great beads. He thought that he had eaten something which had disagreed with him, and yet he had taken but crackers and milk an hour or two previously, which had never disagreed before. On palpation a spot of maximum tenderness was felt exactly at Robson's point. In order to make the diagnosis positive, I requested him to make use of some simple measures for relief, and held off all opium, promising to return in an hour. I could relieve his fears of appendicitis, as the pain radiated upward, instead of downward, and was above the level of the navel. I returned in an hour to find him wearing a happy expression and evidently much relieved. He informed me that during one of the attacks of retching and vomiting the pain had suddenly ceased. He passed his finger with confidence over the place which was very tender before, and informed me that only moderate tenderness remained. For twenty-four hours or more there was some tenderness. There was no trace of jaundice, and no trace of bile in the urine. His appetite returned at once. Pulse and temperature were normal. Would not such an attack as this be considered usually as a mere digestive upset, especially if he had been eating largely of the seasonable fruits, etc.? Yet this man had eaten nothing but a small portion of crackers and milk. Little more than fluid came up with his vomiting. Why, then, was he suddenly relieved by the vomiting? In this case the stone had moved into the pelvis of the gall-bladder, and the spasmodic pain was produced by attempts of the muscular wall of the gall-bladder and orifice of the cystic duct to pass the stone onward through the duct. The attack of vomiting was, of course, attended with the usual muscular relaxation accompanying nausea and vomiting, and in this case it was sufficient to allow the stone to drop back into the gall-bladder, thus causing a cessation of all symptoms. This is the so-called "vomiting of gastralgia," and if the attack does not masquerade under the diagnosis of indigestion it is put under that of gastralgia. Nausea and vomiting are reflex symptoms of biliary obstruction,

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and the most common of its manifestations. They are likewise the most common symptoms of indigestion, but there they are due in part, at least, to the direct irritation of the stomach. The diagnosis should be made by the exclusion of the ordinary causes of indigestion and by the tenderness present in the gall-bladder area. Murphy has suggested a valuable method for the routine examination of suspected gall-bladder disease. He says: "The most characteristic and constant sign of gall-bladder hypersensitiveness is the inability of the patient to take a full, deep inspiration when the physician's fingers are hooked up deep beneath the right costal arch, below the hepatic margin. The diaphragm forces the liver down until the sensitive gall-bladder reaches the examining finger, when the inspiration suddenly ceases as though it had been shut off. I have never found this sign absent in a calculous or infectious case of gall-bladder or duct disease." Not long ago I was called in by a brother physician who had made a diagnosis of diaphragmatic pleurisy upon himself. He had been seized suddenly with pain under his right ribs, which would not allow him to take a deep breath. Sneezing was torture to him. Examination showed the tell-tale tenderness of the inflamed gall-bladder, and the history showed a previous similar attack some years before. It is no uncommon experience to be told by some colleague of his woman patient who has called him up in the night to relieve her sudden attack of "gastralgia." He gives her a hypodermic injection of morphine, which has a quieting and relaxing effect, the stone drops back into the gall-bladder as in the relaxation of vomiting, and the attack is over for the time. When I hear "gastralgia" and the hypodermic use of morphine mentioned together I feel that the probabilities are large that the case belongs to the surgeon. There should be no excuse for overlooking recurring cases of gall-stone colic, and with careful examination of the abdomen in all instances of acute abdominal pain, the diagnosis may be made with the first attack and the patient duly warned. Some months ago a physician residing at a distance requested me to run in to see a patient of his living a few doors from my house who had called him in the night for an attack of severe abdominal pain. He had been prevented by his own sudden illness from responding to the call and notified me in the morning. I at once responded, only to find the patient up and dressed, with a returning appetite. His wife said, "Only an attack of indigestion," and suggested the possibility of Welsh

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rarebits, etc., the night before. But the patient said "No," emphatically, and declared that he had eaten nothing that night, and had had his Welsh rarebits on previous nights with no trouble whatever. As I looked over his abdomen, he placed a single finger over Robson's point and located his trouble very positively "right there," and swore that he had never suffered any pain comparable to that in his life before. He insisted on the right-sided location of the trouble without previous suggestion of mine. It is not uncommon in gall-stone colics to find that the patient has been unusually abstemious before the attack, which at once counts against indigestion. I shall be interested to know the future of the patient just mentioned who had no knowledge of gall-stones, but gave me a very characteristic list of findings of a first attack.

Why are these simpler cases of gall-stones so frequently overlooked, and why is the correct diagnosis often never even suspected? Simply because they are not accompanied by jaundice! As Moynihan states, "Jaundice is a rare symptom of gall-stone disease, unhappily. If jaundice occurred more frequently than it does there would be an earlier and more frequent recognition of the disease." Gall-stones and jaundice are so inseparably connected in the minds of the majority of physicians that it forms one of the great stumbling-blocks in diagnosis. The class of cases we have been considering is that in which the gall-stones are confined to the gall-bladder itself and have not succeeded in making their way out into the bile ducts.

It is therefore physically impossible, for such stones to obstruct the flow of bile into the intestine through the main bile duct. In a small number of cases jaundice of slight or moderate degree may occur through extension of catarrhal inflammation along the mucosa lining the cystic duct to that of the common duct, or by a deposit of peritoneal exudate, which compresses or kinks the common duct, or by direct compression of the common duct by a stone impacted in the cystic duct. After repeated attacks of inflammation, the gall-bladder originally distended becomes gradually much contracted, secondary to inflammatory infiltration of its walls and slow absorption of its contained fluids. It may be so completely shrunken as to become obliterated like the inflammatory obliteration of the appendix. But, as a rule, such a gall-bladder remains the subject of a chronic cholecystitis, with no more distinct colics, but with recurring attacks of acute inflam-

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mation and local peritonitis, and often slow ulceration into stomach, duodenum, or colon. Adhesions to the pylorus may cause stenosis with dilatation of the stomach and interference with its motility, and the case becomes one of chronic dyspepsia. A feeling of fulness and flatulence comes on during a meal, with dull, diffuse pain or aching in the right hypochondrium, perhaps running into the back or shoulder. Pressing the fingers deep in under the right costal arch here as the patient attempts a deep breath will elicit the characteristic tenderness. An early history of colic in such a case is also of great help in determining the underlying cause of the dyspepsia.

It is not my intention to dwell upon the far more serious aspects of gall-stone disease, when stones have made their way out into the common duct, remaining there to open the way to the most serious conditions of poisoning through chronic jaundice (cholemia), septic cholangitis, abscess in liver or lung, pyemic infections of distant organs, or fatal disease of the pancreas. The digestive organs are seriously affected here also, but the more severe symptoms overshadow the digestive symptoms, and there is much less likelihood of a mistaken diagnosis.

If we have made our diagnosis of gall-stone disease as the under-lying cause of our so-called dyspepsia, what shall be our treatment? It remains only to be said that the consensus of the best surgical opinion is to operate for the removal of the gall-stones at the earliest favorable moment after the diagnosis has been made, if no important contra-indications to an operation be present. The situation is the same as in the case of the diseased appendix—the future of the patient is uncertain. If the diagnosis be made early, while the conditions are still favorable, the mortality is practically nil and the cure almost certain. On the other hand, without surgical treatment, a considerable proportion of cases will be doomed to prolonged suffering or invalidism, and will die of septic inflammations of the bile tract or peritoneum, or of cancer originating in the gall-bladder as a result of the irritation of gall-stones. Medical treatment can only be palliative, as there is no evidence that medicine can remove the gall-stones after once developed. Trips to Carlsbad may allay the symptoms for the time being, but in the end may work more harm than good by allowing the patient through delay to slip from the simple stage of cholelithiasis into the complicated. In a series of 456 cases of simple gall-stone disease reported by the Mayo

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Brothers, of Minnesota, the mortality was less than one-half of one per cent., a showing fully as good as in the interval operation for appendicitis for patients of the same age. Changes produced by obstruction and infections in another series produced a mortality of three per cent. The group of cases with common-duct obstruction, which included about one-seventh of the total number of cases operated on, was accompanied by a mortality of ten per cent. Four per cent. of their total number had developed cancer, and the operative mortality here was twenty-one per cent. In practically all of these cases of cancer, gall-stone irritation could be shown to be the cause of the malignancy.

The moral of these results is evident. Early diagnosis *can* be made, and must now be required of the profession at large. And then must follow surgical treatment. With increased knowledge, it may be possible to differentiate medical from surgical cases, but at the present time it can only be said that more lives will be saved, and much more suffering, with surgery, and that the end-results are most satisfactory. Spontaneous recovery due to complete expulsion of the stones from the gall-bladder and ducts must be extremely rare, for where gall-stones have been passed from the bowels, remaining stones have always been found later if the abdomen were opened for any purpose. Gall-stones do not recur after operations properly performed. The operation of choice is cholecystostomy or drainage of the gall-bladder, after removal of the stones. We are operating first of all to relieve the infection in the inflamed gall-bladder, and secondly to remove the exciting cause. In the presence of troublesome adhesions about the gall-bladder, a strictured or occluded cystic duct destroying the functions of the gall-bladder, or suspicious thickening suggesting cancer, the gall-bladder should be removed. Where stones are removed from the ducts themselves, outside the gall-bladder, the ducts should be drained either through the gall-bladder itself, or directly by tubes from the opening in the duct. Drainage openings soon close if recent methods of operation are followed, leaving no fistulæ. Inflamed gall-bladders not attended with stones should be treated by similar surgery with removal of the gall-bladder as the surest method of cure.

CHRONIC ULCER OF THE STOMACH AND DUODENUM

Another of the most common lesions of the upper abdomen which demands accurate diagnosis is chronic ulcer of the stomach

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and duodenum. Here again it is only too frequently the old story of dyspepsia and indigestion, and the patient is allowed to drift miserably along in the severer cases half starved, yet afraid to eat because of pain, perhaps until hemorrhage or septic peritonitis due to perforation bring death and diagnosis together. As in gall-bladder disease, all degrees of distress and disability, mild or severe, may accompany ulcer. That it is much more common than has been generally supposed has been demonstrated. That in the chronic forms it must be considered a surgical disease has also, I believe, been demonstrated. Medical treatment has fallen short in the permanent cure of ulcer, although, as in appendicitis and gall-bladder disease, ofter apparently working a cure for the time being. The surgeons of the Middle West in this country must again receive commendation for the working out of the problems in diagnosis and treatment of ulcer. Especially are we indebted to the Mayo Brothers, who in the little town of Rochester, Minnesota, are doing a larger work in upper abdominal surgery than is being done in any of the larger centres of this country, or perhaps abroad. Their work is of the highest order, very careful diagnosis always being made before operative measures are instituted. They have especially emphasized the fact that both gastric and duodenal ulcers of the chronic variety are far more common than has been supposed.

The stomach wall is made up of four layers, the outer peritoneal coat, the muscular layer, the submucous layer, and the layer of mucous membrane lining the organ. Ulcers of the stomach and duodenum are of three main varieties, first, the superficial erosions or fissures of the mucous membrance, which at times may give rise to alarming hemorrhage; second, the acute round ulcer, which has a clean-cut, punched-out appearance, and generally penetrates only the mucous and submucous coats, but may go on through the muscular and peritoneal coats producing perforation; and third, the chronic, irregular ulcer, which involves all the coats. It is probable that most acute ulcers heal under medical treatment, and the surgeon is only called upon to treat profuse hemorrhage or perforation. A certain small proportion of them become chronic. It is the chronic ulcer with which surgery has chiefly to do. This is not infrequently large, irregular in shape, with margins hard and infiltrated, and the base showing evidence of cicatricial processes. The peritoneal coat is thickened and adhesions may glue it to neighboring viscera,

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especially the liver and pancreas. Chronic ulcer is usually single, while the acute round ulcers are usually multiple. Chronic ulcers are found chiefly in the pyloric region of the stomach. They are more frequently found in men, while the acute ulcer is more frequent in women. It is the acute form which gives rise to the classical symptoms of pain, vomiting, hemorrhage, and epigastric tenderness. This form is most common in women under thirty. The chronic form is more common over thirty, and its complications are listed by Robson as follows: cicatricial contraction of the pylorus, with subsequent dilatation of the stomach, perigastritis leading to disabling adhesions; also, hour-glass contraction, fistula, and tumor of the pylorus or of the stomach; serious atonic motor deficiency; severe gastralgia with uncontrollable vomiting; cancer of the pylorus, tetany, acute and chronic pancreatitis, abscess of the liver, chronic hepatitis, profound anemia (resembling the pernicious form), stricture of the bile ducts, jaundice, catarrh of the gall-bladder, and other complications depending on the invasion of neighboring organs. Both forms are accompanied by pain, great loss of flesh and strength, and at times by subphrenic abscess. It may be readily seen that a large number of these complications are strictly surgical.

Chronic ulcer is usually of the chronic type from its onset, but its course is often marked by periods of acute symptoms lasting days or weeks, followed by longer periods of comfort. These patients go around from one physician or hospital to another, and when the acute exacerbation of symptoms has subsided, they are put down as medical "cures" only to return again, as in the case of gall-bladder and appendical troubles. A careful estimate of medical statistics made from a medical point of view, has led Dr. Sears of Boston to estimate that in cases followed out for five years, sixty per cent. of failures to cure would be found. The most prominent symptom of cronic ulcer, without complications, is painful digestion. The pain may be of burning or boring character, and is usually worse after eating. There is more or less epigastric tenderness, but not the characteristic pain pressure-points, front and back, of acute ulcer. Mayo emphasizes the fact that pain is not constant after every meal, but at one time great pain may follow a light meal, and again a hearty meal will bring no complaint. Pain may at times be relieved by the ingestion of bland foods.

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The pain, however, will often cause the individual to reduce his diet to semi-starvation.

Hemorrhage is no more a common symptom with chronic ulcer than is jaundice in gall-bladder disease, and must not be considered necessary to make the diagnosis. Vomiting is not a marked feature unless there is a mechanical obstruction of the stomach. Gas distention causes great pain. Duodenal ulcer gives much the same train of symptoms as stomach ulcer, but the pain may be very sharp and severe, located to the right of the middle line. The acuteness of the pain, and its presence in the gall-bladder area, cause it to simulate attacks of gall-stone colic. The pain of duodenal ulcer does not radiate beyond the stomach and duodenal area, which, with its marked relation to meals, form points of differentiation. The pain is largely due to the acidity of the gastric juice, and is relieved by dilution of stomach contents or alkalies.

Occasionally a well defined tumefaction may be felt, due to the inflammatory thickening about a chronic ulcer. These thickenings at the pylorus have probably not rarely led to stenosis and death from starvation, no surgical relief being given them on the theory that it was cancer and hopeless. I have recently reported such a case, that of an elderly lady of sixty-six, sent to me over two years ago with a movable pyloric tumor supposed to be cancer beyond doubt, and for whom a hopeless prognosis had been made. She was extremely emaciated and nearly starved. I short circuited the stomach, anastomosing it with the jejunum, and she is living now at sixty-eight, her tumor has disappeared and she is eating a liberal diet. Other cases have recently been reported where patients have been left to die with supposed cancer, surgery not having been advised.

It may be impossible to make a diagnosis of ulcer before mechanical changes in the stomach have occurred. Pyloric obstruction is marked by the stagnation of food contents and the vomiting of material taken into the stomach a day or more before. Distention of the stomach with air or water will show that the greater curvature has dropped below the level of the umbilicus. Chemical examination of the gastric contents will usually reveal a high percentage of free H Cl, whereas cancer will show the opposite, hyperchlorhydria being very constant with ulcer.

A carefully taken history is most important in the diagnosis of these cases, especially of the considerable length of time

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covered and the spells of increased symptoms. Who among us does not recall such cases, which have dragged out a miserable existence as hopeless dyspeptics? They may have passed through the hands of eminent stomach specialists, getting but temporary relief, and the true nature of the lesion being revealed by autopsy only. Such cases warrant a surgical exploration, which can be made with little risk. The excellent work in diagnosis done in the Mayo's clinic is based upon a careful analysis of the patient's history. They consider the elaborate methods and apparatus for stomach examination as often useless and occasionally harmful by causing delay, and believe them unnecessary to the making of a reasonable diagnosis by any sensible practitioner. Careful routine examinations and analyses are always made by them, but while frequently valuable, are of secondary importance. Familiarity with the clinical histories of the various lesions of the upper abdomen, and familiarity in abdominal palpation, should make it possible for the practitioner to recognize surgical cases before too many complications have arisen. Duodenal ulcer will be mistaken for gall-bladder disease, the sharp attacks of local peritonitis in the gall-bladder area simulating gall-stone colic, but both conditions are purely surgical, and the one may not be distinguished from the other until the exploratory incision is made. I have recently seen a case of duodenal ulcer where jaundice acccompanied the inflammatory attacks, passing off later, the inflammatory process occluding the bile duct, closely simulating cholelithiasis.

It will be a long time before the last word is said regarding the treatment of chronic gastric and duodenal ulcer. These ulcers are frequently of large size, from that of a fifty-cent piece to a very large proportion of the stomach area. The treatment at first is, of course, essentially medical. But after an ulcer has gone on for a considerable period, with chronic thickening and hardening and cicatricial contraction about, it is a most difficult medico-surgical problem to cure it without operation. It may be that the poor medical showing in results is due to the fact that treatment is not carried on for a much longer period. The essential of medical treatment must be rest to the stomach through complete abstention from food for a while, and then carefully reduced diet. When the pain has gone, under this treatment, it is by no means likely to have been cured, and treatment must be persisted in for a much longer period. Robson compares it to an ulcer of the

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leg in which the pain ceases when the healing stage begins, but where a great deal more treatment is required. But a chronic ulcer of the leg may be healed with no particular surgical treatment if the patient remain for weeks and months in bed with his leg absolutely at rest. But absolute rest to the stomach for weeks and months is impossible, for, to use an Hibernianism, by the time we got the patient cured he would be dead. Rectal feeding is not always successful in sustaining life. Medical mortality is now placed at from 20 to 50 per cent., according to different authors. The operative mortality in the hands of experienced surgeons is about 5 per cent. It is difficult at the present time to bring together surgical statistics as to the end-results of the surgical treatment of ulcer to compare with those of the medical treatment, but immediate results are often brilliant, and so far as followed offer much more than those of medicine.

How shall the surgeon operate for gastric ulcer? Short circuiting the stomach by means of gastro-enterostomy is the operation adapted to the greatest number of cases, and the results have been so excellent that some enthusiastic surgeons have been accused of making it a "cure-all" for stomach ills. Seventy-five per cent. of all chronic ulcers lie within the pyloric zone of the stomach, and by adhesions outside and obstruction inside the stomach produce interference with its motor activity and dilatation, and consequent pain, vomiting and loss of flesh. Such obstruction and interference are seen in all degrees from moderate indigestion to extreme forms. Making a new outlet from the stomach at its lowest point secures ready drainage of the stomach into the bowel, and by relieving pyloric spasm, hyperchlorhydria and stagnation of fluids creates the needed rest for the healing of the ulcer, and prevents the irritation of the acid secretion and accumulated food. It is quite true that the characteristic excess of hydrochloric acid in ulcer diminishes towards the normal after gastro-enterostomy, as well as the dilatation. Gastro-enterostomy has certain drawbacks, but the chief of them, regurgitant vomiting or "vicious circle," can now be eliminated. Formerly a long loop of bowel was brought up and attached some thirty inches from its origin to the front wall of the stomach. This permitted accumulation of duodenal secretions and other contents, and often great dilatation of the loop, which could not force its contents onwards, and the farther arm of the anastomosed bowel would become collapsed and stomach contents could not

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make their way into it. Finally, a second anastomosis below was devised, connecting the afferent and efferent arms of the attached bowel, thus emptying the contents of the loop without the necessity of its being forced up into the stomach and out again into the farther limb of bowel. Many complicated kinds of intestinal plumbing have been advocated to overcome this supposed "vicious circle," but a comparatively simple operation has eliminated most of the former drawbacks of entero-anastomosis, and should become the operation of choice wherever it is possible to perform it. This is based upon the fact that the origin of the jejunum lies above the greater curvature of the stomach, hanging vertically behind the stomach wall, and would be directly in contact with it did not the transverse colon intervene. By making an opening in the transverse meso-colon, the stomach may be attached at its lowest point, directly to the commencement of the jejunum with no loop at all. The mechanics of this operation are excellent as compared with former operations, and the wonder is that it was not done earlier. No second entero-anastomosis is necessary. Regurgitant vomiting does not occur after this operation. The specimen I present to you here shows how beautifully this anastomosis acted in a case of cancer of the stomach done by me two years ago. The stomach in this case became practically a funnel through which the food gravitated into the intestine, which enlarged in calibre and muscular power, evidently taking upon itself the function of the deposed duodenum.

Moynihan is a vigorous supporter of gastro-enterostomy without any attempt to excise the ulcer itself. This will suffice for the great majority of cases, but occasionally excision of the ulcer will be required. In some cases of cicatricial contraction of the pylorus as a result of healed ulcer, Finney's operation of gastro-duodenostomy—whereby the lower end of the stomach and pylorus and several inches of the duodenum are attached and thrown into one—may be very useful. Experiments recently made by Cannon and Blake, by performing gastro-enterostomy on cats, and then feeding them with food mixed with bismuth, making it possible to watch the course of the food with the X-ray, gave the following result. When the pylorus was open or partially open, food was carried past the anastomotic opening by the peristalsis of the muscular lower end of the stomach and forced out at the pylorus, none going through the new opening. These

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experiments would go to favor Finney's operation in open ulcer, but there is no question as to the good results by the other method.

Rodman has advocated cutting out the ulcer-bearing area of the stomach—the muscular pyloric region—in fit cases, closing the lower end of the stomach and the upper end of the duodenum, and making a lateral anastomosis between the remaining portion of the stomach and the jejunum.

The Mayos do not operate on the relaxed and dilated stomachs so often found in neurasthenic individuals, or the subjects of general enteroptosis. They do not believe operation of benefit in these cases, and warn against bringing stomach surgery into disrepute by mistaking these cases in diagnosis and by performing gastro-enterostomy on dilatations not due to organic obstructions. On the other hand, certain cases who have had their appendices removed, movable kidneys made fast, gall-bladders explored, and perhaps an ovary removed or the uterus fixed, as the supposed origin of reflex pain referred to the stomach, will be found to suffer from duodenal or gastric ulcer. And, too, when adhesions are found binding duodenum, pylorus, or other portions of the stomach, these operators do not rest at the mere separation of adhesions—which will re-form again and probably reproduce the same symptoms—but they determine and treat the original lesions which gave rise to the adhesions, whether it be ulcer or cancer within the organs, or gall-bladder disease, or other cause without.

Acute hemorrhage from ulcer requires occasionally surgical measures to control it, and usually gastro-enterostomy suffices. Acute perforation of ulcer must be treated surgically by appropriate suturing, combined, if necessary, with gastro-enterostomy.

DISEASE OF PANCREAS.

Time permits hardly more than mention of disease of the pancreas, but it should not be omitted, for it plays its part in the disturbances of the upper abdomen, producing "dyspepsia" in the chronic forms and death in the acute forms, unless timely surgery prevent. Many physicians have almost forgotten the existence of the pancreas as a well-defined organ, would not recognize it if they saw it, and do not take it into consideration in making a diagnosis by exclusion in upper abdominal disease. Its deep situation makes disease of the organ more difficult of

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chance of cure. The technique of radical stomach surgery has so vastly improved in the past few years that the immediate mortality in properly selected cases for the radical operation has been reduced in the hands of the Mayos to seven per cent. Of taken for disease of the stomach, adhesions present binding it material from the upper abdomen is required in these cases as early as possible. Chronic pancreatitis is not infrequently mis- to disease of neighboring organs. Gall-stones blocking the outlet to the common duct of the liver draw back also the pancreatic motility and dilatation, with vomiting, etc. The chronic thick- diagnosis, and at the same time exposes it to affections secondary secretion, or turn back the infected bile into the pancreatic duct, thus forming the chief known cause of the extremely fatal acute pancreatitis. Fitz, of Boston, the pioneer who has opened up our knowledge of pancreatitis, as he did of appendicitis, says: "Acute pancreatitis is to be suspected when a previously healthy person or sufferer from occasional attacks of indigestion is suddenly seized with violent pain in the epigastrium, followed by vomit- firmly to duodenum and stomach, producing interference with slight rise of temperature." Incision and drainage of infective circumscribed epigastric swelling, tympanitic or resistant, with ing and collapse, and in the course of twenty-four hours by a ening of the head of the pancreas often found in operating for gall-stone disease simulates cancer and disappears if the gall- bladder be drained, and the bile flow diverted to the outer world for a sufficient period. I have diagnosed and cured by operation a pancreatic cyst where the patient was for a long time treated for dyspepsia. Finally, abdominal palpation was done by the attending physician, and an anatomical change recognized, which brought her into my hands. Who can estimate the years of valuable time and the many valuable lives lost through neglect to early palpate the abdomen in all painful and persistent conditions arising therein?

CANCER OF THE STOMACH.

In closing, a word must be said about the early diagnosis and treatment of cancer of the stomach. In surgery lies the only hope of cure at the present time. Cancer is on the increase, and cancer of the stomach is the most common form of it. As in cancer elsewhere, very early radical removal offers the only

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cases recovering from operation five to eight per cent. have been reported as remaining cured. The operation is as fully indicated in early cases as the Halsted operation for the radical treatment of cancer when occurring in the breast. The percentage of cures should in future be much greater than in the past if the surgeon may only get his cases early enough. The surgeon familiar with the upper abdomen now stands ready to do an operation which promises much if his medical brother will co-operate with him. It is not the operation of complete extirpation which he offers, as that is a piece of surgical gymnastics rarely or never indicated. Sixty to seventy per cent. of all gastric cancers begin at or near the pyloric area. The fundus and two-thirds of the greater curvature are free from lymphatic involvement in cancer of the pyloric area. Therefore, resection of the pyloric area and lesser curvature is sufficient in early cases, and the "immune area" is allowed to remain, being sutured in to form a reduced new stomach, and the duodenal opening likewise closed off. Then the continuity of the alimentary canal is restored by bringing up a loop of jejunum and attaching in by a lateral anastomosis to the new stomach—a much easier and safer procedure than anastomosing the duodenum directly to the stump of the stomach. But this operation should not be attempted in advanced cases with numerous adhesions. Here gastro-enterostomy should be done by the method previously detailed, preferably with the Murphy button, and life prolonged and rendered more comfortable, but without hope of cure.

How is the diagnosis of early cancer to be made? All medical means have been disappointing in early diagnosis and there is no pathognomonic sign. The absence of free H Cl in the stomach is a late rather than an early sign, and secondary anemia and cachexia are likewise late signs for which we must not wait. In exploratory incision lies our present means of diagnosis, if possible before the disease has advanced to the detection of tumor. There is practically no risk in this in an early case. The delay in diagnosis occurs because the diagnosis of "dyspepsia" must first be labored with in the commencement by the patient himself, later by the physician. When cachexia is well advanced the search for tumor is made, and then the case is turned over to the surgeon too late for a proper radical procedure. Robson says: "Whenever a patient over forty years of age complains somewhat

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suddenly of indefinite symptoms of gastric uneasiness, pain and vomiting, followed by a progressive loss of weight, secondary anemia, and so forth, the possibility of cancer should be at once recognized." Osler said, as long as five years ago: "In a suspected case, when under treatment there is no improvement in a few weeks, an exploratory operation is justifiable." These are wise words, and if followed there would be a great advance in the treatment of cancer of the stomach. But the difficulty is to arouse the profession to "suspect" the case. Though we have been repeatedly told that from 35 to 45 per cent. of all cancers occur in the stomach, still we continue to cling to our old friend "dyspepsia" as a disease, rather than a symptom of disease, and this latter possibly cancer, the most fatal of all. A melancholy history told me only yesterday illustrates this well. A man of 46, of fine physique and robust health, began to suffer last December from dyspepsia. He tried his own little remedies at first and then went under the care of a physician. But he continued to lose weight and his symptoms increased. He went to another physician who said he knew just what the difficulty was and promised him a speedy cure. Returning to his home after an absence, his friends were astonished to find his large form much reduced and his skin of an unhealthy pallor. Altogether, he visited several physicians, the last telling him that he was suffering from "paralysis of the nerves of the stomach"! Not one physician stripped him, nor examined his abdomen, and not one suggested cancer. When he finally entered the hospital, four or five weeks ago, a growth and involvement was revealed nearly as large as the hand, not permitting of even a palliative operation. To be sure, there were a few uncommon symptoms, but when a patient with every hall-mark of cancer of the stomach stamped upon him is put off month after month with trivial diagnoses, by several practitioners, it suggests a sad lack of knowledge of disease in that quarter.

On the other hand, much good work is being done on every side in the newer aspects of these important diseases of the upper abdomen, and a few years hence the results of our surgical treatment will be widely diffused and the lessons learned put into daily practice by physician as well as surgeon. That the coming of this time cannot be too quickly brought about is my excuse for laying it before you at such length this afternoon.

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DISCUSSION.

DR. HENRY A. FAIRBAIRN said he did not wish to detract in the slightest particle from the credit due our surgical brothers for whom he had the profoundest respect—he might say love and admiration. He had no desire to discredit what they say, but after a companionship of thirty years in hospitals and outside of hospitals, he put them down as no better diagnosticians than their medical brothers, unless they got their eye on the lesion through the instrumentality of the knife. Periodically the human anatomy is shaken by what might be called surgical waves incited by enthusiasts and extremists. Extirpation has been their characteristic cry without due regard to function in the rest of the economy. The tubes, the uterus, large portions of the digestive tract have figured as trophies in these disturbances. Extirpation, splitting the capsules, decapulation of the kidney; these enthusiastic advocates brook no delay when they see a focus of trouble. Perhaps following one of the dictates of the twentieth century to get there at all hazards, they remove all portions of the body in the way, leaving for the clinicians what may be left, or possibly for the pathologist.

As Dr. Westbrook has shown, there is a focus of surgical activity above the umbilicus, and the cycle of activity is much the same as we have seen in other regions. There is an attempt on the part of certain individuals to solve all intricate pathological problems by operation on the offending organ. Let us study the records from the East; from our midst come reports of doubtful results, reports of large mortality. One man in the East reports a long series of cases with fifty per cent. mortality. The speaker did not wonder in the face of that, that these peripatetic patients go around from doctor to doctor. They want to avoid surgeons in the face of a fifty per cent. mortality. From the West come more rosy reports. The Mayos report some 1,100 cases of gall-bladder operation with a mortality of six per cent. What does all this mean? It lets a great light on the whole subject. If you are going to invade this region your indications must be urgent and they must be positive.

When we meet a gall-bladder which contains stones, it is surgical property: It ought to be emptied out. The passage of these stones may cause death by shock, or they may cause ulceration or they may cause obstruction. An infected gall-bladder is surgical property. Let it stand, it may infect the whole organism.

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The speaker asked how do we expect ulcerations of the stomach to heal, and answered the question by saying we expect them to heal by the careful treatment of the clinician. If the patient will come to the clinician in time, surgeons will not have so many ulcers to operate on.

DR. R. W. WESTBROOK said we have lived through a good many stages. The mistakes we have made we have been taught by. All these things are true which Dr. Fairbairn said, but we have gotten beyond this stage.

As to the matter of surgery above the umbilicus, the statistics have been appalling. He had seen pylorectomy after pylorectomy die; he hated the operation. In the hands of the best men he had seen all kinds of bad technic responsible for that, but that should be a thing of the past. The surgeon must learn the upper abdomen. Some men have learned it and the statistics which they are presenting are the statistics of very careful and very able work.

As to the matter of diagnosis, you can not make the diagnosis; the diagnosis of early cancer can not be made. Medicine has absolutely failed. There is nothing left but exploratory incision. Osler took that position long ago, and that is what the speaker wanted to emphasize. Make the incision early before there are complications. There is no risk in the making of an exploratory incision in uncomplicated cases. Make it late and there is great risk. Exploratory incision has its logical field for diagnosis in the class of cases he had mentioned and Dr. Fairbairn had also mentioned.

As to the surgical results in chronic gastric ulcer, we have not as yet the full statistics. We can only say that the results are most promising. We do not go into the stomach and treat every ulcer. The man who has published the best statistics of all, Moynihan, of England, does nothing but a gastro-enterostomy. It produces cure by one essential thing: it gives rest to the stomach.

The speaker presented a specimen of cancer of the stomach, and said it had been taken from a man who did not have a dilated stomach; he did not have the ordinary cancer, but he had a cancerous involvement about three inches in diameter, and he was practically starved to death. He did not know exactly why. The man would not take food. He did not have vomiting. The speaker opened the abdomen and explored, and found that

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he could do a gastro-enterostomy, which he did, and the man lived comfortably fifteen months afterward. How that gastro-enterostomy set that stomach at rest and gave the man so much longer lease of life, he did not quite know, but he did know there is nothing more satisfactory than the operation of gastro-enterostomy, and it sets the stomach at rest and allows the ulcer to heal. Gastro-enterostomy is being advocated by some enthusiasts as practically a cure.

This matter of surgery of the upper abdomen will be in five or six years from now on a better basis than at present. There is a great deal to be said in the differentiation of medical and surgical cases.

THE CONSERVATIVE TREATMENT OF URETHRAL STRICTURE.

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To many it may seem that the last word has been said upon urethral stricture, that the various forms of treatment are clearly laid down in the modern text-books on genitourinary surgery and that there is little left to be written upon this subject.

On the contrary I believe that the average general surgeon and even some genitourinary men have a very wrong conception of the condition and the treatment usually indicated. Many of these men are teachers in the medical colleges and the students are told that urethral strictures should be dilated when that is possible, and when it is not they should be cut, either by internal or external urethrotomy. This is correct and while certain men may have very proper and well defined ideas as to when dilatation is impossible and when cutting should at last be advised, there are too many surgeons who have but a poor understanding of the possibilities of dilatation or else too little patience and practice to manipulate the tight stricture of small calibre. Cutting, therefore, is frequently advised in cases that should be dilated.

Strictures fall into the surgeon's hands in one of two ways: The patient has retention, and his family physician is unable to enter the bladder with either his soft rubber catheter, silver cathe-

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ter, or even perhaps with the Gouley instrument, and the surgeon is called. Other cases present themselves for treatment without any acute symptoms, the patient knowing that he has stricture and appreciating an increasing difficulty in voiding urine, becomes alarmed and seeks his physician's and subsequently the surgeon's aid.

I venture to state that in both classes of cases, if the stricture be fairly tight and dense, the surgeon will recommend some cutting operation. He will be particularly likely to so advise the patient if the latter is a workingman who has little time and money to devote to the improvement of his urethral calibre. It has long been common teaching that the man of this class can be cut and returned to his regular occupation almost immediately, while time can only be spared for dilatation by the individual of larger means and greater leisure.

This is one of the greatest errors that have been passed to succeeding generations of surgeons. The poor man, after a so-called successful urethrotomy, leaves the hospital, passing a greatly improved stream of urine, and feeling quite confident that his trouble is over. He is told that sounds must be passed at more or less frequent intervals for the succeeding year, and that if, after that time, no contraction occurs, he will be cured. That he does not in the great majority of cases return for this treatment is a matter of common knowledge to all surgeons in institutions where much of this work is done.

It requires but little knowledge of surgical pathology to appreciate the fact that cut surfaces in constant apposition, are more than likely to unite even if urine is regularly passed over them, and this is the condition after all internal and many external urethrotomies. Agnew[1] said: "However valuable may be incision, it must not be deemed a radical cure for stricture, notwithstanding what is said to the contrary by sanguine urethrotomists. The 'splice,' of which so much is said, and which occupies the gap between the sides of the divided parts, is granulation tissue; and the resulting cicatrix will always retain that invincible power of contraction. The tendency to contraction in the canal, it is true, is lessened, but it is not destroyed; and hence the patient must be instructed to pass a metal sound once or twice every month if he expects to keep out of the hands of the surgeon at some future time."

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The brilliant results claimed by active urethrotomists have no doubt in many cases been due to the fact that the supposed stricture was really a point of physiological narrowing in a normal urethra.

Dr. Otis taught that the urethra was a tube of even calibre from the bladder to the meatus; and that any encroachment upon its lumen was a stricture, and should be cut.

Four points of narrowing exist in the normal urethra.

1. At the meatus.
2. At the proximal end of the fossa navicularis.
3. About midway in the pendulous urethra.
4. At the bulb.

It is easy to understand that "splicing" a normal urethra in a young man will "cure" his "stricture."

The main objections to cutting operations are the following:

1. Several weeks' detention from business, a very serious drawback in these days of active struggle for existence.

2. The fact that, after operation, the individual has to be treated for a year or more, in practically the same manner as if no operation had been done, and his stricture had been gradually dilated.

3. The mortality rate. This is a much disputed point, but I believe it to be at least five per cent. in both internal and external urethrotomies.

J. William White[2] makes the following statement regarding mortality from internal urethrotomy: "The practitioner who decides to cut a stricture anterior to the bulbo membranous juncture, must do so with the full knowledge that there are at the very least two chances in a hundred of losing his patient. There should certainly be definite and well-grounded reasons for accepting this risk, and the operation which involves it should show results unmistakably superior to those of gradual dilatation, —a procedure with practically no mortality."

A trifling operation that is so easily done that it is done far too frequently, is meatotomy. While it is often necessary to enlarge a meatus, it is easy to cut too freely, and the resulting lack of resistance to the stream of urine, sometimes interferes seriously with the muscular tone of the bladder. The gaping meatus also invites venereal infection.

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I will not enter in detail into the treatment of stricture by gradual dilatation. This paper has been written as a plea for this more conservative means of treating stricture, and I will only mention briefly what I believe to be the important points in a method of treatment that is not new, but is neglected by some colleagues.

In men beyond middle age the anterior urethra should be thoroughly flushed before any instrumentation. In younger men it is safer to make this a rule, although I do not believe that the sound bladder is easily infected by the germs ordinarily found in the anterior urethra.

As a lubricant for urethral instruments, vaseline should never be used. It has been found in the center of calculi in the bladder, and is difficult to remove from instruments.

The best lubricant is made from Irish moss, and contains a small percentage of formalin. The lubricant should never be applied to the instrument by the hand of the surgeon, a common and most unsurgical procedure. It should be dropped from the container upon the meatus, and the sound or other instrument passed through it.

In endeavoring to find the opening in a stricture with the filliform guide, I have found filling the urethra with a number of the straight instruments, and successively attempting the passage of each, to be more successful than the use of the instruments with the variously twisted ends.

Most of us were taught to never use force in the passage of sounds. This I believe to be good teaching and should be followed by those of little experience in the urethral instrumentation. If it were lived up to by the genitourinary surgeon, many dilatable strictures would have to be cut.

In the use of tunnelled sounds in very tight cases, without force the instrument would never enter the bladder. This is equally true of larger plain sounds. How much force can be used and how to direct it, can only be learned by experience.

It is a good practice to irrigate the bladder and urethra after any instruments have been passed. In some tight strictures this is exceedingly painful, and I therefore instruct my stricture patients with healthy bladders to hold their urine for a couple of hours before treatment. It is voided immediately after dilatation and irrigates the urethra without discomfort to the patient.

Most authorities advise the passage of two sounds at each

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treatment, one to be the size of the largest passed at the previous treatment, and the second, one size larger. I have found it more comfortable for the patient to pass one sound, increasing one number each time.

The element of spasmodic stricture is usually added in cases of retention due to true stricture. On this account it frequently happens that not even a filliform guide can be passed. Under general anesthesia this spasm is relieved, and instruments can frequently be passed with little difficulty.

Strictures due to gonorrhea may occasionally be seen that require cutting, but I believe they are few and far between. Certain congenital strictures and those of traumatic origin require operation. The operation of choice in strictures anterior to the bulbo membranous juncture is that suggested by Reginald Harrison;[2] combined external and internal urethrotomy. This with perineal drainage gives absolute rest to the divided parts.

In closing I will report several cases that I believe illustrate the value of this method of treatment.

CASE I.— J. F., 49 years of age, was referred to me on May 13, 1905, at 1.30 A. M., by Dr. F. J. McDonough for retention of 20 hours' duration. I was able to relieve his retention with a small Gouley catheter. At 9.30 A. M. of the same day he again applied for relief and was catheterized with the same instrument. He gave the following history: Several attacks of gonorrhea, the last in 1886. Was operated for stricture by a prominent general surgeon of Brooklyn in 1900, internal urethrotomy. Was up and about the ward a day or two after operation and left the hospital a week later, able to pass a good stream of urine. He was instructed to report at frequent intervals for the passage of sounds. This he never did. He had three attacks of retention in the year before I saw him. All relieved with soft catheters. During the six weeks following his first visit to me I dilated his stricture to 25 French, after which he discontinued treatment.

CASE II.—J. B., 24 years of age, referred to me by Dr. Sewell Matheson, July 24, 1905. He had first consulted a well-known Manhattan specialist, who was unable to enter his bladder with any instrument, and who told him that an operation would be necessary. History: Had gonorrhea eight years ago, and for past five months had noticed increasing difficulty in voiding urine. His stricture, which was at the bulbo membranous juncture, was passed without special difficulty with an 11 French tunnelled

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sound. He is still under treatment and this week I passed a 26 French sound. This case well illustrates the folly of cutting the poor man. This man was in receipt of a very moderate salary; his wife nearly at term, and several weeks in the hospital would have been a great hardship.

CASE III.—G. W., 51 years of age. Was taken in the ambulance to the Williamsburgh Hospital, July 9, 1905. Retention for 16 hours. No previous trouble. No history of gonorrhea. Several physicians had endeavored to catheterize him without success. The only instrument that could be made to enter his bladder was a filliform guide. He was anesthetized with ether and the Gouley catheter passed with some difficulty. Since then he has been dilated to 28 French and is still under treatment.

CASE IV.—A. H., 27 years of age, referred to me by Dr. A .C. Jacobson, August 15, 1905, by whom he had been treated for two attacks of retention. The first time I saw him was in the hospital where Dr. Jacobson had sent him, feeling sure that some operation would be necessary. I was able, with the use of considerable force, to pass an 11 French tunnelled sound. This was followed by free bleeding. Since then I have been able to pass larger sounds up to 24 French, and he is still under treatment. There is some bleeding after each dilatation. This man was operated upon by a surgeon in Manhattan four years ago. Internal urethrotomy. His stricture was dilated for some months after the operation, contraction occurring again later.

CASE V.—A physician came to my office at 6 A. M. on May 27, 1905. He had been unable to urinate for the preceding 17 hours. Three preceding attacks of retention. Gonorrhea ten years ago. Only a filliform could be passed to the bladder; the effort to introduce a Gouley catheter along the filliform produced very free bleeding.

He was taken to the hospital, anesthetized with ether and the Gouley instrument passed quite easily. He has been dilated to 24 French, and is still under treatment, which I regret to say he has not continued very faithfully.

DISCUSSION.

DR. JOHN D. SULLIVAN said that a few years ago a paper was read on that same subject by one of our members, a very

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prominent surgeon in Brooklyn and a teacher of genitourinary diseases. He advocated in all small strictures cutting the urethra, and he brought some very good arguments to bear in support of his views. At that time the speaker took occasion to differ with the reader of this paper, and stated that he had been able during twenty-five years or more to treat all strictures that were permeable by gradual dilatation. He has continued that practice up to the present time. Occasionally he has to do an external urethrotomy and has to cut the urethra all the way through. He was glad to hear Dr. Muren take the stand against cutting, because the custom and practice of to-day is to cut the majority of strictures of the urethra of anything like a small calibre. Dr. Sullivan thought cutting did not cure them. When once a stricture has formed there is an infiltration into the mucous membrane and in the deeper strictures which becomes organized. Cutting through one margin or side of the stricture does not cure it, for he had been called on to dilate a number of strictures that had been cut.

The speaker makes it a practice as a rule to commence gradually with the largest size sound he can get in, first taking steps to cleanse the urethra, and he would say that he commenced this practice before we knew anything about antisepsis. He had very little trouble at that time, did not do anything in the way of washing out the urethra, and only very seldom did he have any trouble following it. Any disagreeable feature that ever did come in the way of passing a sound was in the nature of a chill which seemed to follow the instrumentation. He had come to the conclusion that there was a marked pathological condition over and above the stricture that caused the chill and fever that followed, either a chronic cystitis, or the man's system was in such a condition, loaded up with toxines or uric acid, that a slight traumatism of any kind would produce a chill, and that is the only objection he ever had to passing sounds.

Occasionally, he said, you will find some men on whom it is rather hard to pass a sound. Put them under treatment and get them in good physical condition and you can then treat their urethra, beginning with small-sized sounds, and two or three days later on passing to larger instruments. He has these patients come to the office twice a week. As a rule he passes two or three sounds at a time, commencing with one that will go in easily. He always puts a solution of cocaine into the urethra and waits a minute

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or two. After having treated the patient for three or four times, he makes it a custom to leave the sound in the urethra and massages along the course of the urethra, rolling the stricture between his sound and the fingers outside. He takes five to ten minutes to massage each stricture. The next time he can pass a larger sound. In that way he continues the treatment. He has had a number of patients who are completely cured. He knows these strictures become completely absorbed by the passage of the sound and massage. The speaker thought anything irritating does more harm than good. In strictures in old subjects there is more or less cystitis and venous congestion, and the urethra about is in that condition. After two or three months' treatment the congestion and the firmness that you feel will disappear, and the man will have a good, almost normal urethra, he believed, and a better urethra than he would have if a urethrotomy had been done, and also with less danger to the patient and loss of time.

DR. W. MADDREN agreed with the reader of the paper in the main. He has always considered himself rather ultraconservative, as far as the treatment of these strictures are concerned. He believed, if you are willing to give the time to them that you can always stretch them, with a few rare exceptions. He remembered in his younger days working four hours on a case with the patient in a hot bath, without being able to get into the bladder, but succeeded subsequently and did not have to cut that case. It takes a lot of patience and a lot of time. In hospital cases you cannot do it; the internes cannot give the patients the time, and they have not the patience. In private practice you can do it if the stricture is not traumatic.

His custom has been to use cocaine solution. He has used 10 per cent., has seen some unpleasant effects from it occasionally, but never had any bad results. He uses some of the lubricants and has applied them otherwise than as the doctor had expressed. He has used his finger, but cleansed the hands thoroughly first. Some lubricants do not adhere to the instrument as well as by smearing them with the hand.

The better treatment of stretching strictures is with a steel sound rather than with the more modern instruments that are covered with rubber. You get through quicker, although the sound does not stay in as well.

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In regard to the after treatment, the chills; of course, if you have ammoniacal urine you have to treat that. The patients are apt to get a chill after passage of a sound. Dr. Maddren prepares his patients sometimes as a matter of routine by giving a small dose of quinine, and prepares the bladder when he has time and opportunity to do it by the administration of formalin or urotropin or some of its preparations and gets the urine as aseptic as possible, which you cannot do very well while a stricture exists.

The result of his experience is that the stretched strictures remain dilated better than the cut, and if he had a bad stricture he would prefer to have somebody take the time and thoroughly stretch it than cut it, and he knew the effect would last longer. There are a few strictures that have been stretched to 36, 38 or 40, and which will stay stretched for a long period of time—ten to fifteen years. One case that he operated on he tested twenty years after he cut and stretched, and he could pass a 40 sound as well as when the patient passed out of his hands. He had not been stretched for a period of eight to ten years.

DR. G. M. MUREN, in closing, said that it is an unwise thing to use cocaine in dilating strictures. Of course, a man who has done a lot of this sort of work thinks he has some extraordinary facility in passing a stricture. With the use of cocaine much of the pain is done away with, and he would rather have the patient so that if he is badly hurt, he will say so. He thought instead of using cocaine for a stricture, which is very difficult to pass, he should rather give the patient a general anesthetic. He thought this difficulty is more often seen in cases of retention where the element of spasm is often added to the true stricture.

Dr. DeForest had asked about the method of irrigation. The speaker uses the Janney-Frank syringe and flushes out the anterior urethra repeatedly. It may not and does not wash out the germs, but in an ordinary case it is the best method to use. In irrigating a stricture patient, an old man, after a sound has been passed, he would use cocaine to overcome the resistance of the cut off muscles, which prevents any irrigation into the bladder. In an individual accustomed to bladder irrigation experience accustoms him to relaxing the cut off muscle. The strength of cocaine he uses is one-half of one per cent. and he has never seen any poisoning from it. In the University Clinic, where they

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have 60 cases a day, they have not had any poisoning in several years.

As to the solution used for irrigating the anterior urethra, plain water, if heated, is as good as anything. If you suspect gonococci are present, protargol or some silver solution can be used.

In regard to the chill following the passage of the sound, he did not believe there was as much of that to-day as surgeons met with twenty or thirty years ago. In those days instruments were not boiled as they are at present.

In regard to the preparation of the patient before the dilatation of a stricture in an elderly man with cystitis or any infection, urotropin and irrigation of the bladder, if you can get in, will be very much better.

As to passing several sounds at each sitting, he could not approve of that, merely because it is more uncomfortable for the patient. The stricture patient is a nervous individual. If he has the stricture for some time his general health is impaired and he is more or less of a nervous wreck. If you want to have him come back for after treatment, it is better not to do too much at one time. That is why he did not jump from a 20 to a 24 sound at one sitting, which is easy to do.

Dr. Sullivan had spoken about a cure. He did not believe many strictures are really ever cured, although a great deal of the stricture tissue is absorbed. The most important part of the treatment is the massage and not the stretching. If he had a stricture he should prefer to have it dilated and go to his surgeon twice a year to have a sound passed and be sure it had not contracted rather than to have it cut, because the result is the same after the cutting operations.

As to the complication of gonorrhea with a stricture: if a man had any sign of a discharge and came to him for treatment he would not consider his stricture until he found the organisms in the discharge, and if he had a gonorrheal discharge he would let the stricture go until he cleared up the gonorrhea. In some tight strictures you might not be able to irrigate into the bladder. He would wash out the anterior urethra, first using cocaine and anesthetize the cut-off muscle and wash out the bladder. He would do it every day at first and then a few times a week. When the gonococci had disappeared he would treat the stricture. Those with gonorrhea of two or three years' duration frequently

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have a morning drop, while some of them have a free discharge; at least they have a gleet which contains many gonorrheal germs.

Dr. Maddren had said that hospital cases cannot be given the time. A good many hospital cases that are brought in on the wagon are retention cases, and most of them in poor men, and they do not want to stay in the hospital; they may have families to support. If you can relieve their retention you can let them come to the dispensary and be treated and have their strictures gradually dilated. It is not absolutely necessary that they should be cut.

In regard to the finger for applying a lubricant, he had seen many men, who should know better, use vaseline from the bath room in a private house to lubricate the catheter, which they had previously boiled. The vaseline is swarming with germs. If from a clean container a thin lubricant was poured on the meatus, the hand need not touch the end of the sound at all. Dr. Maddren might believe that he can wash his hands absolutely clean, but he doubted that very much.

Dilators had been spoken of. The speaker felt quite sure that no dilator can compare with the sound for the constant even pressure on the stricture, which gives it the massage needed.

A question being asked as to the kind of lubricant employed by Dr. Muren, he answered that formerly he used a preparation known as Lubricoll, but now has the same thing made by his pharmacist for ten to fifteen cents a can. In answer to a further question Dr. Muren said he had no experience with eucaine.

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MORE RAPID CORRECTION OF LATERAL CURVATURE OF THE SPINE.

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For clinical purposes, scoliosis or lateral curvature of the spine may be divided into these three groups depending upon the duration and severity of the deformity:

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I. Those one-sided body leanings and spinal deviations due to muscular weakness only and such as can be corrected voluntarily.

II. Those in which structural changes are present but not fixed. (Fig. 1.)

III. Those in which structural deformities are quite fixed.

The treatment of lateral curvature will vary with the degree of the deformity, but we may lay down the principle that there is no stage in the progress of the condition which is not benefited by systematic general exercise and special muscular training. It is, however, the author's belief that this muscular training may be aided and the training period materially curtailed by intermitting with the use of correcting plaster of Paris jackets when structural changes have commenced. This paper describes a method which it is believed combines comparative comfort to the patient with efficiency.

In deformities of the first degree, or those due to muscular weakness only, I believe that exercise and the proper establishment, in the patient's daily routine, of hygienic living, with all that that implies, are alone called for. From the first sign of habitual body-lean or spinal deviation to one side more than the other, systematic, persistent and vigorous physical training must be undertaken and carried out for a number of months under the physician's personal care and then for a still longer period at some well established gymnasium, the patient coming at stated intervals to the doctor for re-examination and suggestion.

The patient should undergo such treatment until the boy or girl is much stronger than his average fellow.

With those patients in whom structural changes have commenced, we have these to overcome, as well as to establish the muscular tone. Certain pullings and liftings by the operator, especially when assisted by intelligent effort on the part of the patient, tend to stretch contracted muscles and ligaments. Machines also, some simple and some elaborated, have been devised to overcome resistance. They are used perhaps daily or every other day for a few minutes at a time. If persisted in they will do much. However, within a few minutes after the removal of this outside support, whether that supplied by the operator or by a machine, the patient will "slump" back into the faulty position. Although he can more easily pull himself back to a posture

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approaching the symmetrical one, he is nevertheless carrying himself for the greater part of his waking hours either hanging, as it were, from his weakened muscles and ligaments and thereby increasing their atonic stretching, or is resting unduly on the sides of the bodies of the vertebræ, and thus making them more wedge-shaped, or both these conditions are present.

We have therefore three mechanical factors in this second class of lateral curvature—factors which are constantly operative, and which tend rapidly toward the third class in which the fixations are much more permanent. I refer to

(1) the muscular and ligamentous contractions on the one hand,

(2) the muscular and ligamentous stretchings and later atonic relaxations on the other, and

(3) the beginning wedge formation of the bodies of the supporting vertebræ and interfibro-cartilage.

In congenital club-foot, we encounter exactly these mechanical factors. Our treatment by stretching the contracted muscles little by little and holding that little for a week or so at a time in plaster of Paris dressings until finally we have over-corrected the faulty position and nature has readjusted the abnormal structures, is very satisfactory in the various forms of talipes. Professor Lorenz has shown the application of the principle in the correction of congenital dislocation of the hip.

Why do we not apply this treatment to lateral curvature of the spine? In the first place it is much more difficult, and again the abuse of the plaster jacket for scoliosis has been so great that we naturally incline to discard it altogether. But in this I believe we lose a valuable corrective agent.

When the elder Sayre applied the first plaster jacket, he suspended the patient vertically from the jury-mast with head harness, the strain coming upon the head and neck and the arms. Dr. Sayre used graphically to describe his anxious watching for untoward cerebral and other nerve symptoms during many hours of that first day. Although having the advantage of knowing that this method has been successfully used thousands of times since, I wonder if we did not experience a little of that anxiety over our first plaster jacket. It is to avoid the fright and real discomfort and often pain and to obviate the consequent sense of hurry on the part of the operator, as well as to accomplish greater correction of the deformity, that the horizontal is substituted for

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the vertical position while applying the jacket. This method requires more paraphernalia than the older one, but the condition to be corrected is complicated, and, I believe, deserves the greater preparation.

A gas-pipe frame, seven feet by two feet, with a fixed smaller frame, two feet by eighteen inches, extending at right angles from one end, is laid horizontally at convenient height upon two

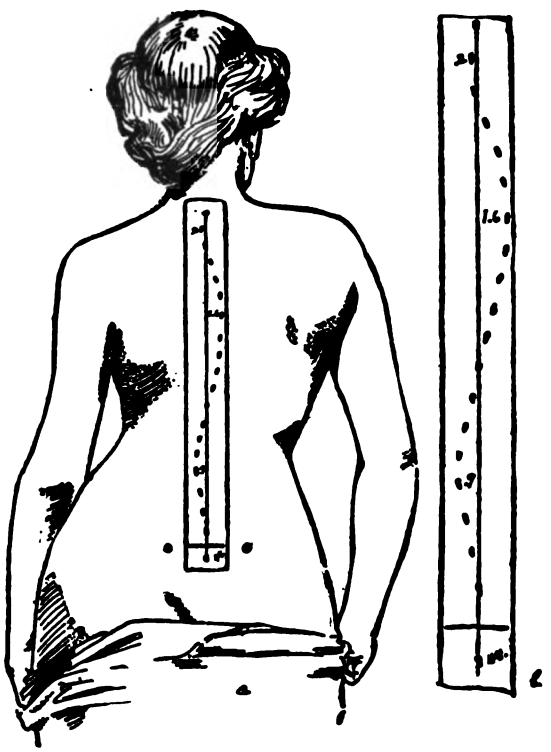

Fig. I. a. Typical case, with right dorsal and left lumbar deviation and with leaning of body to the right. b. Adhesive plaster tracings of the vertebral spines.

carpenter's horses (Fig. 2). The gas-pipe bar at the end of the large frame opposite the right-angled extension, has six or eight strong pegs on which to support one end of a hammock, and is so placed in the joints of the frame that it can revolve. A turn-screw and a retention pin, at one end, make this rotating bar adjustable. Along the middle of the large frame is stretched a stout canvas hammock, six or eight inches wide, according to the

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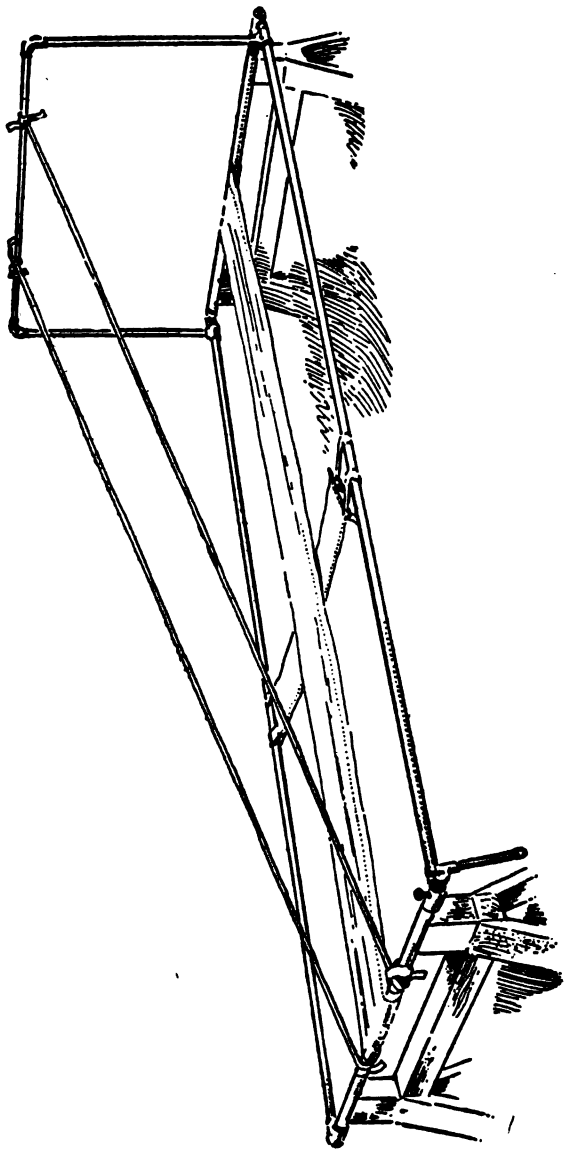

Fig. II. The Frame, with hammock and long webbing bands applied.

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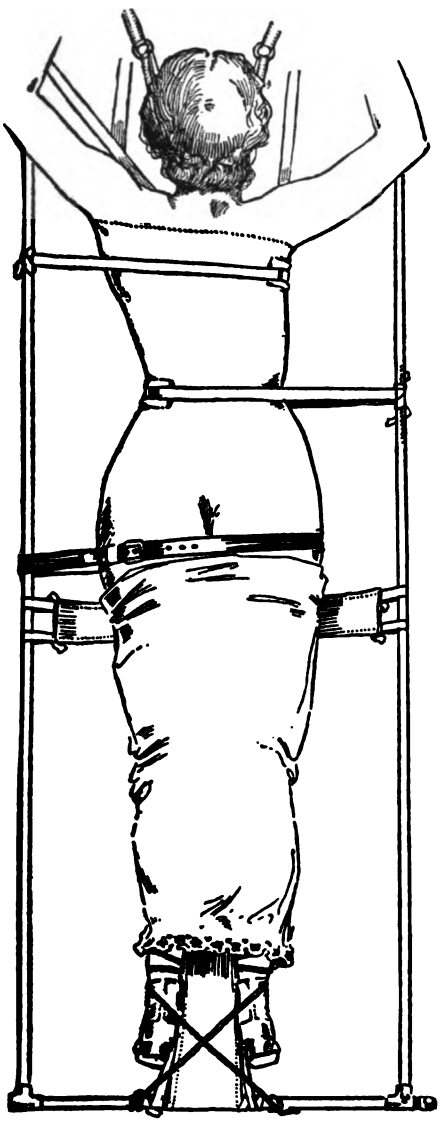

Fig. III. Patient in position with traction forces applied. Seen from above.

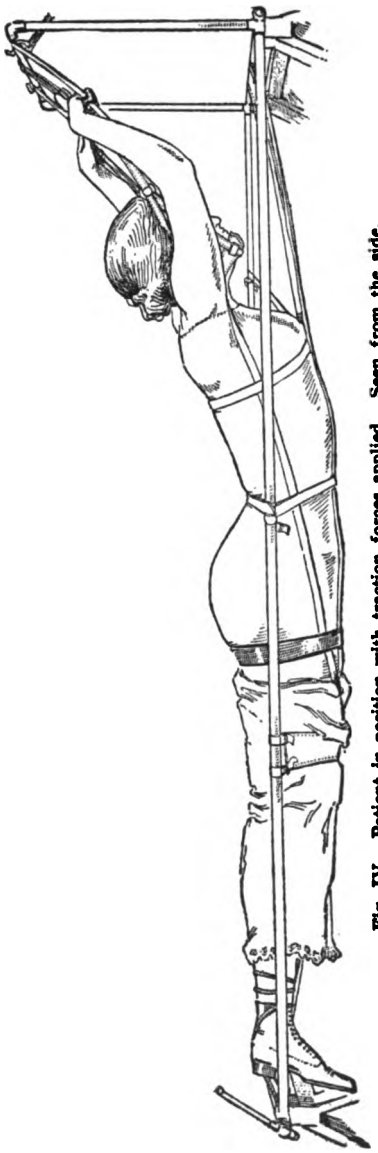

Fig. IV. Patient in position with traction forces applied. Seen from the side.

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size of the patient, one end to pegs on the immovable end of the frame, the other to pegs on the rotating end. Two pieces of stout webbing bands are stretched from the cross-bar of the right-angled extension to the revolving bar of the large frame. These pieces of webbing are added for the better retraction of the shoulders, and are separated from each other at the measured distance between the patient's shoulder joints. If the patient is heavy, a transverse belting is stretched between the sides of the large frame, underneath the long canvas hammock and at about the place where the upper third of the thighs will rest. A few turns of the revolving bar will make the canvas and the webbing tight and the adjusting pin will hold them so.

The patient, properly prepared with stockinette shirting, the long pieces of flannel bandaging for "scratcher" inserted and exposed bony points suitably padded, is now placed prone upon the canvas and webbing hammocks, with hands temporarily grasping the extension cross-bar. There will be a little sag in both hammocks, but they will be equalized and the extra height of the fixed end of the webbing will still hold the shoulders back (Fig. 3).

The longitudinal and lateral correcting forces are applied in the following order (Fig. 4); First, a rope or bandage anchors the feet to the lower bar. Then the familiar head-extension apparatus with ropes and pullies draws head, neck and arms (the hands now resting on the cross-bar of this apparatus) gently toward the high cross-bar of the frame. The lateral traction straps are now applied. If we are dealing with the most common form of scoliosis, namely, a right dorsal and left lumbar double curve, with general sway of the trunk to the right (Fig. 1), a strong strap is passed around the pelvis, just below the level of the trochanters, and around the long bar at the left side of the frame. This is made simply snug and it will act as counter-traction to the strong pull which is to be made on the left side of the waist. The traction band for this is made of a piece of strong webbing to which has been sewed a broad and fairly thick pad of piano felting. The pad is placed over that portion of the patient's left side which corresponds with the greatest lower deviation of the spine. A moderate pull is made on this webbing to draw the lower spine toward the right, and the ends of the band are secured about the right side of the frame. It may now be found that enough elonga-

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tion of the spine has occurred to make it possible to take in a little slack on the head-extension apparatus. A similarly padded webbing band is now applied to the right side of the chest a little below the level of the right side spinal deviation and pulled and tied to the left side of the frame. The pad is placed just below the situation of the greatest right side deviation, because one end of the traction band pulls directly sidewise while the other, that which would otherwise press upon the breasts of an adolescent girl, is made to pass diagonally between the breasts and pulls partly headward. This also increases the longitudinal pull advantageously. Perhaps another taking in of slack may now be possible at the head-pulling apparatus, although any discomfort here is unnecessary. One should avoid too great correction with the first jacket, or the stretched muscles would cause the patient pain afterward. One should draw on the lateral traction straps to just short of the patient's present discomfort.

The patient now lies in comparative comfort and the operator may with deliberation apply the plaster of Paris bandages. As one wishes to combine the greatest strength with the least of weight in the jacket, the material for the bandages should be of the best. It is well to have ready also shoulder re-traction straps, fastened to pieces of tin in such a way that the latter may be incorporated into the last few turns of the plaster, one under and just back of each armpit. A similar piece of tin supporting webbing and buckles is incorporated at the back of the jacket. (Fig. 5.)

The plaster bandages are applied snugly to the patient's figure from the trochanters to the armpits. The encircling rolls include the canvas and the webbing hammocks and those portions of the traction straps and pads which lie close to the stockinette covering the patient. When the ends of the traction straps are reached, the edges of the bandages are brought close to and then passed by them. Care is taken to make as little bulging here as possible. When the plaster has nearly set, the ends of these lateral traction straps are cut away close to the jacket, and the small holes covered by a turn or two of plaster bandages.

The entire frame, including the prone-suspended patient, may now be lifted from the supports to a long table. The head and foot traction gears are removed and the canvas and webbing hammocks drawn from beneath the plaster jacket, the

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lower ends of each having been first freed from the frame by unwinding the revolving bar. The patient now lies on the table entirely free from the frame which may therefore be placed at one side.

Fig. V. The jacket applied. a. Seen from the side, noting the retraction of the shoulders. b. Seen from behind, noting the incorporation of the supports for shoulder retraction straps. c. Seen from the front, noting the low cut to allow thoracic breathing.

There is nothing unusual in the trimming of the plaster jacket except that the use of shoulder-retracting straps makes it possible to hold the shoulders well up and back, and yet to cut out the upper front of the jacket to about the level of the nipples to afford fuller chest expansion. (Fig. 5.)

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When the jacket has firmly set the patient stands up and the shoulders are drawn well back by the shoulder-retracting straps, which are then buckled. If the tractions have been properly applied, a marked improvement will be observed in the carriage of the trunk in relation to the hips. Especially will it be noted that the slump to one side—usually to the right—has been in great measure, overcome. (Compare Fig. 1 and Fig. 3.) The carriage of head and shoulders also should be distinctly better.

It is usually well to provide for the administration of some form of anodyne for the first night, as there will have been stretching of muscles which may cause temporary discomfort.

If this jacket has set evenly and strongly, it may be worn for three or four weeks, especially if the patient goes through some daily arm and leg and breathing exercises to keep in good condition. Other jackets are applied in the same way. In changing from one jacket to another the patient should not be allowed to stand or even to sit up, although he should then have the advantage of thorough soap and water and alcohol and water bathing. At each succeeding application of plaster of Paris, more and more correction is sought by greater tension upon the traction straps. The author has not yet used more than four consecutive plaster jackets on a given patient, but believes that he could get greater correction by using more or in some cases by intermitting with the use of brace and exercises, returning to plaster of Paris after a few months. The latter procedure is often of distinct advantage as the return to exercise improves the general tone of the patient, just as the cessation of hard exercise and temporary rest in the plaster of Paris jacket has frequently been observed to benefit the general condition.

Just before applying the last jacket, measurements are taken for the brace, for there must be no sudden removal of the support.

A modification of the Knight special brace, with careful attention to the details of shoulder straps and of laced traction bands, has been found useful. For a year or two, at least, this brace or its successors should be used, and not removed except for bathing and for exercise.

Too much emphasis cannot be laid upon the importance of keeping up as much exercise as possible, while wearing the plaster jackets, and, on the substitution of the brace, of resuming vigorous gymnastics. The traction pullings and plaster of Paris holdings will have overcome structural changes to just such an

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extent as, in the doctor's judgment, it has been wise to go; but the weak muscles have not become stronger, although they will more quickly recover their tone because of the rest, and they must be developed.

In conclusion, the author is at present unable to give a final report as to results of treatment, as he is now caring for eight or ten patients who are at various stages of the treatment, no one of whom he considers cured. But the results, so far, have been so satisfactory in causing distinct improvement that it seems worth while to present the method now in the hope that others may use and improve on it. The corrections gained have remained to just the extent that the patients have been willing to follow up the vigorous exercise.

It is an open question whether or not it is advisable to try to overcome the deformities of extreme scoliosis, especially when there seems to be evidence that ankylosis between vertebræ has partly compensated for the loss of muscular and ligamentous support. The development of the upper chest by breathing exercises will usually relieve the dyspnœa of these conditions.

SUMMARY.

1. Systematic physical training is the main therapeutic agent in the correction of lateral curvature of the spine.

2. Structural changes cannot be overcome by muscular effort alone.

3. Plaster of Paris jackets, applied under conditions of progressive longitudinal and lateral traction and frequently renewed, will rapidly overcome muscular contraction, and are advantageously employed in suitable cases of moderate severity.

4. This treatment must be promptly followed by the use of a brace and vigorous physical training.

DISCUSSION.

DR. WILLIAM B. SAVAGE said that in connection with the doctor's paper he would like to make a plea for a certain class of cases which develop lateral curvature, and that was in most cases of amputation of one leg in children. Some years ago he had occasion to amputate the femur of a child six years of age for tubercular knee joint. The child made a fair recovery and passed from observation for a period of two years, when he

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again saw the child with an advanced lateral curvature. During this two-year interval the child had been on crutches without any artificial limb, and had no doubt developed lateral curvature by reason of the change of the center of gravity of the trunk by the loss of the leg, and in using the well leg the spine had tilted to that side. On behalf of that class of cases in children, the bones being soft, he would ask that no amputation be made, unless some proper provision be made beforehand for the furnishing of an artificial leg to retain the original center of gravity. Since that time, eight years ago, he has seen three other cases, and each one has a lateral curvature.

DR. ELIAS H. BARTLEY said that he saw more of these cases when in dispensary practice than in recent practice, but had never used this horizontal method. He had always used suspension according to Sayre's plan. He could conceive this method is far better than the other and easier, because one can take their time in applying the bandage.

Dr. Bartley has used a brace for the last ten years constructed according to his own ideas, so as to allow of as much freedom of movement as possible, and applies it mainly in school girls. He has been very much pleased with the results. The brace simply consists in supporting the shoulders upon the hips and allowing perfect freedom of forward and backward movements, there being no brace behind the back to interfere with motion. He believed that freedom of movement is of great importance. Of course, some kind of support must be provided for, and he accomplished this by simply going from the basal point up and putting a regular crutch under the arm, so that with an extension apparatus he could raise the shoulders up, lifting one higher than the other, or adjusting it any way he saw fit. In that way he had very good results in straightening these cases. The brace was made of iron or steel and worn under the clothes.

DR. JOHN D. SULLIVAN said that in a clinic in London in 1885, at which he was present, the surgeon had an apparatus with two poles like a narrow bed. From each post he had a piece of canvas as wide as the patient's body. He laid the patient on that piece of canvas, had his assistants straighten out the spine, whether lateral or posterior, and got the body in as normal position as possible. He took plaster bandages, wound

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them around the body, including the canvas and all. The canvas was then cut away in the shape of the jacket he wanted and the patient carried to bed.

DR. H. BEECKMAN DELATOUR congratulated the author on the development of this plan. Those who have used the old Sayre method, he said, agree in the disadvantages of it. Just as you are in the midst of putting a plaster on before it sets, the patient faints and has to be lowered and part of the advantages are lost. It certainly is enough to frighten the average child to string him up by the neck, and it seemed to him that this method of Dr. Truslow offers a very good solution to that part of the treatment. It further appealed to him that you are able to get traction against your points of curvature, a thing impossible in the upright position, or which, at least, is not applied. He believed that is an important part of the procedure.

Dr. Delatour said it was certainly a good thing to have this subject brought before the Society and before practitioners generally. He believed curvatures of the spine are too frequently overlooked in the beginning, and it is not until the curvature becomes great enough for rotation to have taken place, when the prominent hip calls the attention of parents to the condition of the child, that the lateral curvature is discovered. If these cases were only put in the proper hands early, the results certainly would be very much better.

The speaker was glad that the doctor advocates not the continuous and exclusive use of the jacket, for it has always been his belief that exercise of the muscles was also an important part of the treatment. He did not believe many men were in position to take care of these cases and treat them properly. They are cases for the specialist, because they take time and care to properly apply the jacket. He had seen patients strung up and bandages put around the body without any thought apparently of getting anything more than a plaster of Paris support. That certainly is not all that is to be accomplished in these cases.

DR. TRUSLOW, in closing, said that with regard to the question as to those forms of lateral curvature due to unequal length below the pelvis, as pointed out by Dr. Savage, of course, one knew that even the existence of flat foot on one side may

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cause an unequal length below the pelvis and a coxavara, and other conditions where there is an unequal height of the pelvis, and therefore the pelvis is habitually tilted to one side or the other. He did not mean the habitual standing position of the child growing up, but he meant where there is a definite anatomical reason for the tilting of the pelvis. It is much more encouraging when you find that out, and then such a treatment as advocated is very much quicker in its results, because you have not other factors at work, the factors of weakened muscles of the spine, which is a distinctly hard thing to overcome, even with hard persistent exercise.

The speaker believed that the brace of Dr. Bartley was correct in being pivoted backward and forward. They must not be pivoted sideways because the pelvic band is the base on which to hold the spine above and you must get a firm brace in that position.

In regard to the question of the hammock, this method of the horizontal position in the frame consists in just a big piece of strong unbleached muslin for little children and canvas for older children. As to the idea of the horizontal position Dr. Truslow said he had been at fault if he gave any one the impression that it was original with him. It is practiced in the Ruptured and Crippled and in the Johns Hopkins Hospital. In the hammock, even if there is a little sagging, in children with bad Pott's Disease, letting them sag down a little bit in the prone position has a distinct tendency to correct the actual condition present.

The question of whether cure, or whether improvement, to say the least, is possible if there is ankylosis, the speaker replied that in the paper he did not wish to go into that question, because he had not felt he could answer it. During the week he had a chance to read of some work done by Lovett, of Boston, in which he speaks of using the prone lying position, but he uses strong force outside by pressing instead of pulling.

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A BRIEF RESUMÉ OF RECENT WORK IN DISEASES OF THE URINARY TRACT.

By HOWARD A. KELLY, M.D.,
BALTIMORE.

As their lineal successors, we the practitioners of medicine and surgery of to-day naturally look back with deep interest upon the methods and practices of our forefathers so diverse from our own. He can be little less than a philosopher who scans the pages of the long list of great men and notes the successive changes which have taken place within the past two and a half years. A profound interest centers in the queries, "Were the changes evolutionary or catalcylsmal?" "What germs of truth have been handed down from age to age?" From such queries we turn naturally to the conditions which surround us to-day to inquire whether medicine seems at last to have reached her goal, or whether an evolutionary process is still in progress.

We cannot apply the telescopic method here, but must be content with the microscope studying, in short periods of time noting small things.

Stimulated by these reflections I would like to talk to you for a little while of the great changes which have taken place in my own particular field of work within the short period of about twenty years. I shall not speak of the gynecological field at large, but solely of that branch which deals with diseases of the urinary organs. I trust that this may interest you, as it is the latest scion from the surgical tree, and one which is still rapidly growing.

When I began my work in the early eighties, one serious condition affecting the urinary tract had but recently been studied and mastered, and that was vesico-vaginal fistula. The patient labors of several generations had at last borne their fruition in the brilliant achivement of Sims and Emmet. And Emmet had gone so far as to use drainage through an artificial fistula for intractable cystitis.

From these little beginnings, when contrasted with the great field to be covered, the field has grown to a size whose boundaries I hope to outline this evening.

I will take for an example to illustrate the importance of my subject, a thousand consecutive cases from my own practice, 500

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from the Johns Hopkins Hospital (August 27, 1904, to March 26, 1905,) and 500 from my private hospital work (from March 4, 1903, to January 13, 1906).

In the 500 cases in the Johns Hopkins there were:

Diseases of the kidney and ureter		25 cases
Floating kidney	11 cases	
Tuberculosis	6 cases	
Other renal diseases	7 cases	
Ureteral diseases	1 case	
Diseases of the bladder		22 cases
Cystitis	19 cases	
Other diseases	3 cases	
Total		47 cases

That is to say 9.4 per cent. of my work in the hospital is devoted to cases entering because of urinary diseases.

This list does not, of course, include any urinary affections arising in the hospital, or incidental to other gynecological affections, or any operations done upon such cases.

In my private hospital in the series of 400 cases analyzed, I find I have treated one hundred and twenty who came to me especially for disease of the urinary tract. This does not include a large group of cases incidental to other affections.

The urinary cases constitute therefore twenty-four per cent. of my private work. They were divided as follows:

Analysis of last 500 cases in private hospital:

Urinary tract cases		120 or 24%
Kidney	61	
Bladder	55	
Ureteral	4	
Tubercular	4	

I will not present an analysis of my earlier records, but trust you will accept my assurance that the percentage was small (for the most part vesico-vaginal fistula and cystitis) and the development in the line of urinary work has been a remarkable one.

This change has been brought about by the following factors, which we might pause to consider for a few minutes, if only to cultivate as we deliberate, a due sense of thankfulness for the

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blessings which have been conferred upon us within so short a time.

The gross result is clearly the outcome of a painstaking attention to all urinary cases, when out of the obscurity almost before we knew it there gradually emerged certain newer *methods of diagnosis,* which began at once to give great precision in differentiating a whole group of maladies previously indistinguishable.

The most striking result of this advance was that once and for all the great fields of vesical, ureteral and kidney affections were thus for the first time clearly separated. Where disastrous confusion and obscurity had reigned, order and clarity were henceforth destined to rule supreme.

The exact nature of certain heretofore obscure diseases was at last, by these newer means, clearly determined.

The gravity and extent of a urinary disease could now, as never before, be measured with accuracy.

It has been most stimulating and refreshing to note, too, how graciously history has repeated herself, as with the increasing powers to make an exact diagnosis, both as to the nature, the seat, and the extent of a disease, *surgery,* the offspring of pathology and diagnosis, has grown more and more aggressive, and has been able to prompt relief in cases heretofore condemned to suffer indefinitely.

I further note with profound satisfaction a most important feature in the change of attitude in the relation of the physician to these urinary diseases, which is manifested in an ever-growing readiness to investigate even minor complaints; in this way earlier diagnoses are being made, and the surgeon has at last a chance to intervene in progressive serious affections, while they are as yet localized and curable. I think particularly in this connection of the inestimable benefits which have accrued in the treatment of renal tuberculosis, and I might add vesical papilloma.

METHODS OF DIAGNOSIS.—The newer methods of diagnosis which have come as quickening factors in this neglected field, are the recognition of the dependance of cystitis, pyuria, and urinary infections upon the presence of micro-organisms, such as the colon bacillus, the staphylococci, streptococcus, pyocyaneus, and other pus-producing organisms, together with the tubercle bacillus. As we work out the particular organism we are also able at the same time to form an estimate of the *grade of disease* in many

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instances, by noting the number of organisms found in a measured quantity say three platinum loops of urine. By taking cultures at intervals and by recognizing a decrease in the number (using the same measure), we are also able to estimate with an accuracy sufficient for practical purposes, the progress of the patient towards recovery.

CHEMICAL DIFFERENTIATION OF THE PYURIAS.—A most important means of diagnosis which has been developed in my own clinic by Dr. Thomas R. Brown, simultaneously with numerous similar observations abroad, has been the ready differentiation of the renal and vesical pyurias, simply by noting the amount of albumin present. A vesical pyuria yields but a slight trace, while in a renal pyuria there is a distinct ring of albumin with the nitric acid test. By attention to this little sign one is often able to predict with certainty and in advance of the local examination, that a given case is one of pyelitis rather than cystitis, or that a mild cystitis is dependent for its persistance upon a pyelitis from above. In this way the attention is focused on the organ which is really at fault, and much time and useless treatment may be saved.

We must note here, too, among the precious things recently acquired in this field, that a presumptive diagnosis of tuberculosis of the kidney must be made in all acid pyurias, in which an organism refuses to grow out on the ordinary media. The injection of the centrifugalized sediment under the skin, or into the peritoneal cavity of the guinea pig are decisive factors in confirming the diagnosis. In a doubtful case it is well to take this step at once to save time.

PALPATION OF THE URETERS.—I am glad to have this opportunity of calling your attention to an important, but still much neglected, diagnostic point. It is about twenty years since that eminent, and much-loved surgeon, Max Sänger showed us that the vesical ends of the ureters could be palpated without any difficulty. As the normal ureters are found to be so easily within touch, experience has shown that it is yet more easy to detect and examine diseased ureters. A tubercular ureter feels like a thickened, hard, and in its later stages, nodular or moniliform cord. A stone struck in the lower end of the ureter also has a characteristic hard, bony feel. In a number of instances, in some of which the diagnosis had not been made, I have been able to set the question

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entirely at rest, literally within several seconds, as rapidly as I could carry my finger into the vagina, and sweeping it over the anterior wall; on one side there would be no unusual resistance at all, while the other was found occupied by a thick, hard ureter, which felt like a lead-pencil splinted in the tissues. I cannot say too much in extolling a method of diagnosis so simple and so certain as this.

THE CYSTOSCOPE.—The next new factor, which has become an indispensable handmaid in the investigation and treatment of these affections, is the ability we now have of inspecting the interior of the bladder, whether by the mediation of a series of lenses or directly through an open tube or cystoscope. If one should study a figure of the female pelvis with rectum, vagina and bladder, all of them distended with air, then he would appreciate the difference between it and the classical Kohlrausch picture, although it has been copied in a recent text-book with the patient in the dorsal position, in which case the distention would instantly disappear. Attention is drawn, by means of this picture, to the accessibility to all parts of the rectum up even into the sigmoid, by using a large cylindrical tube, as well as to the accessibility of the bladder through a small tube, say 1 cm. in diameter.

THE URETERAL CATHETER is the most important instrument recent years have conferred on us for the detection of diseases above the bladder, as well as for the differentiation of the urines of the two sides. Speaking more particularly of my own work, I would point out that I have always used the shorter catheters, and that I habitually use larger catheters than can be used through the male cystoscopes in vogue. Where I dilate strictures, I can use a round-pointed catheter, or a conical point, or a delicate point or even a catheter cut square off at the end. I can also introduce catheters varying from 1½ to 1¾ mm., all the way up to 3 mm. in diameter. In this way I am able to dilate strictures of the ureter in a manner impossible with other cystoscopes.

URETAL AND VESICAL CALCULI.—The wax-tipped bougies still prove to be invaluable in locating stones in the ureter, which they invariably find, as well as indispensable in revealing the presence of stone in the kidney in most instances.

By injecting fluid into the kidney I am constantly differentiat-

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ing cases of obscure pain in the side, many of which have been taken to be ovarian, or cases of appendicitis, or even stone in the gall bladder.

In all, over 150 of these cases have been analyzed by my associate, Dr. H. T. Hutchins, with the following results:

1. In by far the greater number of cases the actual pain which formed the patient's complaint and brought her to the Hospital was reproduced by the injection of the kidney. A few typical examples are given as follows:

Gynecological No. 10365. Date, March 28, 1903. Miss A. W., aged 40. Complaint, pain in the right side and back for ten years.

Examination: The right kidney is movable to the second degree and tender.

The right kidney was injected with sterile water. 8 c.c. caused the patient to exclaim, without questioning, "Oh, Doctor, that is the pain which troubles me." The injection was repeated the next day with the same result.

Operation: Fixation of the right kidney, with following relief of symptoms.

2. Many cases of which the above is a type could be cited. In 13 cases a differential diagnosis was made and kidney diseases ruled out. A good example of this is the following case:

Gynecological No. 9666. Date, May 24, 1902. Mrs. A. W., aged 30. Married; four children. Complaint, frequent micturition and pains in sides, indefinite and of different kinds.

Examination: Kidneys are not palpable; no abdominal ptosis.

The right kidney was injected, with the patient in the left lateral position. 17 c.c. of the fluid caused pain, but the patient exclaimed, "This is an entirely new pain. I have had lots of pains in my side, but that is different from them all." By this examination disease of the kidney was ruled out.

Operation: Abdominal, with removal of right tube and ovary, containing an old encapsulated tubal pregnancy, with adherent appendix. The uterus was suspended and the outlet repaired.

3. Diagnosis of dilatation of the ureter and renal pelvis:

CASE. Sanatorium, Dec. 9, 1905. Mrs. C., aged 31. Married; one child. Weight, 109 pounds. Complaint: pain and lump in the right side; pus in the urine.

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Examination: Right kidney in moderate descensus, not tender; left kidney movable to the third degree.

Both kidneys were injected with boric solution. The right kidney pelvis held 80 cc., and 60 cc. were returned through the catheter. The left kidney pelvis held 35 cc., and 25 cc. were returned through the catheter. This amount of fluid was injected in both sides without producing any pain. A diagnosis was made at once of double hydronephrosis.

Operation: Plication of kidney pelves; fixation of both kidneys; suspension of the uterus and repair of the outlet.

4. A still further application of the principles is the following case:

Gynecological No. 7820. May 16, 1900. Miss M. C., aged 24. Single. Complaint: constant dull aching pain in left side.

History: Patient has always been delicate. Received a strain in left side six years ago; has felt a lump and had pain ever since.

Examination: Patient on her back. Right kidney found to be movable to the third degree; left kidney movable to the second degree and somewhat tender. There is no other abdominal ptosis.

The left kidney was injected, 10 cc. of fluid being used. The pain produced the patient located somewhat lower than the normal position of the kidney.

Operation: Fixation of the left kidney, with relief of symptoms.

In this case the right kidney was by far the more movable of the two, but the less movable kidney was the cause of the pain of which the patient complained.

Many cases of which the above are types could be cited to prove the value of this work, not only as a means of differentiating kidney disease from other disease causing similar pain in the side, but also as a means of actual diagnosis of renal and ureteral disease and the actual measurement in many cases of the amount of trouble.

HYDRONEPHROSIS. I have also found that the injection of the kidney is a precious means of determining the existence of a hydronephrosis, even of lesser grade. By the amount of fluid the

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pelvis holds without reflux into the bladder, a fact readily determined by coloring the fluid, I am able to measure the exact size of a hydronephrosis or a pyonephrosis.

I no longer speak vaguely of hydronephrosis meaning in all instances a tumor sufficiently large to be felt in the loin. I reckon my hydronephrosis from those which hold 10 or 12 cc. of fluid all the way up to those holding several hundred. A case now in my care has a hydronephrosis of 60 cc. on the right side and one of 29 cc. on the left. I am thus often able to associate my hydronephrosis of lesser grade, which are never recognized by the ordinary clinical methods, with attacks of colic due to ureteral obstruction. I am also able to detect enlargements of the ureter.

A recent satisfactory improvement in our technique is the *shadowgraph catheter* devised by Harry Fenwick. These catheters which need no stilette to throw a shadow with the X-ray, serve well to differentiate phleboliths and other extra-urinary sources of shadows.

Before taking up some of my cases in particular, let me briefly consider a question of moment. How far can the average surgeon, gynecologist, or practitioner expect to advance in this special line of diagnosis and treatment?

The essential qualifications in work of the character I am considering are, in the first place, a warm interest in the subject, which must be more or less assiduously cultivated. He who succeeds in this field must find opportunities for the investigation of these diseases in his private practice, or else he must create the opportunity by frequenting some clinic. The interest aroused must be a persistent one, as a fruitful experience is a matter of years of growth. Added to this there must be some little natural dexterity in the use of the instruments such as is shown by the throat or the eye specialist. That these qualifications are not necessarily rare is shown by the success of a number of my assistants in this field.

I feel sure that the general practitioner ought to go at least as far as a thorough microscopic and bacteriological investigation of all inflammatory affections. The tubercular cases ought, also, to be differentiated by the means cited above, as well as by the demonstration of the bacilli which is sometimes most difficult.

I have a word of complaint to utter here against many of my brethren in the field of general practice throughout the length and breadth of our land, and that is that they do not overcome

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their natural repugnance of making vaginal and rectal examinations. I have seen some of our best men treat cases for weeks and months without making a clear diagnosis, when the whole matter would have been cleared up by using these avenues of exploration of the interior of the body. If a patient has a grave abdominal disease and nature has furnished us with two open channels by which we can introduce the hand into a part of the abdomen, I do not see why we should not in every case avail ourselves of these avenues of investigation.

I do not believe that many general practitioners will become skillful in the use of the cystoscope; their field of labor is already too large to enter into such special details.

The paper was demonstrated by seventy lantern slides.

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In Memoriam

HENRY CORNELIUS MCLEAN, A.M., M.D.

University of the City of New York, M.D., 1873.
Member of the Associated Physicians of Long Island, 1899-1904.
Date of death, December 23, 1904.

HOMER LYMAN BARTLETT, M.D.

College of Physicians and Surgeons, N. Y., M.D., 1855.
Member of the Associated Physicians of Long Island, 1899-1904.
Date of death, February 3, 1905.

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HEBER NELSON HOOPLE, A.B., M.D.

University of Toronto, Medical Department, M.D., 1885.
Bellevue Hospital Medical College, M.D., 1885.
Member of the Associated Physicians of Long Island, 1899-1905.
Date of death, May 8, 1905.

RICHARD HENRY SULLIVAN, M.D.

University of the City of New York, M.D., 1883.
Member of the Associated Physicians of Long Island, 1903-1905.
Date of death, March 27, 1905.

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GEORGE TERRY FANNING, M.D.

Bellevue Hospital Medical College, M.D., 1877.
Member of the Associated Physicians of Long Island, 1903-1905.
Date of death, July 5, 1905.

EZRA HERBERT WILSON, M.D.

College of Physicians and Surgeons, N. Y., M.D., 1882.
Member of the Associated Physicians of Long Island, 1898-1905.
Date of death, December 19, 1905.

HOWARD HALSEY YOUNG, M.D.

Bellevue Hospital Medical College, M.D., 1884.
Member of the Associated Physicians of Long Island, 1902-1905.
Date of death, January 16, 1906.

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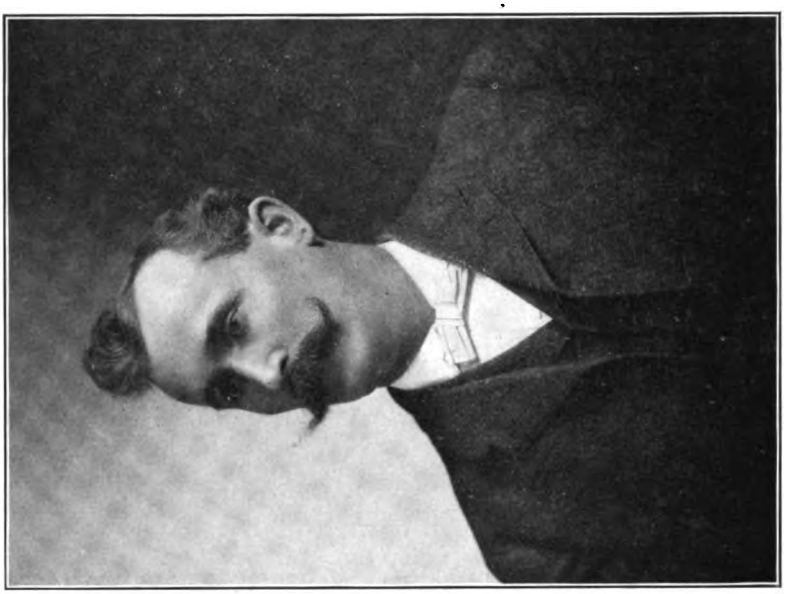

JOSEPH EDGAR WELLS, M.D.

Jefferson Medical College, M.D., 1887.
Member of the Associated Physicians of Long Island, 1901-1905.
Date of death, February 26, 1906.

George Ryerson Fraser

Bellevue Hospital Medical College, M.D., 1871.
Member of the Associated Physicians of Long Island, 1899-1906.
Date of death, February 6, 1906.

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CONSTITUTION AND BY-LAWS

OF

ASSOCIATED PHYSICIANS OF LONG ISLAND

AS AMENDED TO DATE

Article I.

Section 1. This Society shall be known as the Associated Physicians of Long Island. Its objects shall be those of a general and scientific medical society, the study of the natural conditions and prevalent diseases of Long Island, and the promotion of the medical interests by the medical profession.

Sec. 2. Eligibility to membership shall be limited to regular practitioners who are members in good standing of their County Societies, and who have the endorsement of the Membership Committee of the Society.

Article II.

Section 1. The officers shall be a President and a Vice-President, each from one of the County Medical Societies of Long Island; a Secretary and a Treasurer. They shall be elected by a majority vote at the annual meeting.

Sec. 2. There shall also be a board of five Directors, consisting of the retiring President, the President, First Vice-President, Secretary and Treasurer, respectively, by virtue of their several offices.

Sec. 3. Should a vacancy occur in the Board, it shall be filled by the remaining members of the said Board.

Sec 4. Every three years there shall be elected a delegate to the Medical Society of the State of New York.

Sec. 5. The Board of Directors shall have power to appoint delegates to other medical bodies when in their discretion expedient.

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Article III.

Section 1. The following Standing Committees shall be appointed by the chair: A Scientific Committee, a Membership Committee, a Legal Committee, a Committee on Publication, a Historical Committee, and a Committee on Public Health. The Historical Committee shall be a permanent committee, and when vacancies occur they shall be filled by the President of the Association.

Sec. 2. There may also be such temporary committees appointed as are necessary, including a Local or Entertainment Committee for each session.

Article IV.

Section 1. Stated meetings shall be held three times a year, in June, October and January, respectively, the annual meeting to be held at Brooklyn in January, the June and October meetings to be held at places selected by the Board of Directors. Special meetings may be called by the President at the written request of five members.

Sec. 2. For scientific purposes a quorum shall always be presumed. For executive business, twenty members shall be necessary.

Article V.

Section 1. The duties of the officers are explained in their titles. The *Scientific Committee* shall provide the program and have charge of the scientific sessions. It shall be the duty of the *Membership Committee* to secure and recommend new members for the Society. The *Legal Committee* shall have charge of all legislative and legal matters of interest to the profession of the Island. The *Publication Committee* shall provide a channel for the publication of papers, and shall issue a revised edition of the manual after each annual meeting. They shall also provide a book for the registry of members attending each meeting. The *Historical Committee,* which shall be composed of a member from each County Society of the Island, shall collect historical data of interest to the profession on Long Island. The *Committee on Public Health,* which shall be composed of a member from each

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County Society of the Island, shall have charge of all matters pertaining to the public health, and its scope shall also include the natural features and endemic diseases of the Island.

SEC. 2. The Board of Directors shall meet once before each stated meeting and transact all business not otherwise provided for.

ARTICLE VI.

SEC. 1. New members shall be admitted only on the recommendation of the Membership Committee and a two-thirds ballot of those present and voting.

SEC. 2. All applications for membership shall be in the hands of the Membership Committee at least One Month before each stated meeting.

SEC. 3. Every applicant for membership shall sign the printed application blank and accompany the application with the current annual dues.

ARTICLE VII.

The regular dues shall be determined at the annual meeting. Special assessments, not to exceed in amount the annual dues, may be levied by a majority vote at any meeting.

ARTICLE VIII.

SECTION 1. Any member who fails to maintain membership in his County Society shall thereby forfeit membership in this Society.

SEC. 2. A member who is in arrears for two years' dues shall be dropped.

ARTICLE IX.

A member of the bar may be selected as Honorary Counsel.

ARTICLE X.

The following shall be the order of business:

Reading of the Minutes.
Report of the Membership Committee.

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Reports from Other Committees.
Unfinished Business.
New Business.
Scientific Session.
Adjournment.

Article XI.

At the annual meeting the following shall be the order of business.

Reading of Minutes.
Report of Membership and Other Committees.
Report of Secretary.
Report of Treasurer.
Report of Historian.
Unfinished Business.
New Business.
Election of Officers.
Scientific Session.
Installation of New Officers.
Adjournment.

Article XII.

Section 1. Amendments to the By-Laws may be adopted at any meeting, provided they are proposed in writing at the last previous meeting, and receive a two-thirds ballot of the members present and voting.

Sec. 2. A By-Law may be suspended for a specific time, by a unanimous vote.

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OFFICERS OF THE ASSOCIATED PHYSICIANS OF LONG ISLAND FROM ITS ORGANIZATION.

1898-1899.

President: William Browning, Brooklyn.
First Vice-President: Louis N. Lanehart, Hempstead.
Second Vice-President: William A. Hulse, Bayshore.
Third Vice-President: Charles Jewett, Brooklyn.
Secretary: Robert J. Morrison, Brooklyn.
Treasurer: Arthur H. Terry, Patchogue.
Historian: Joseph H. Hunt, Brooklyn.
Chairman Ex. Committee: Henry A. Fairbairn, Brooklyn.

1899-1900.

President: Louis N. Lanehart, Hempstead.
First Vice-President: James M. Winfield, Brooklyn.
Second Vice-President: William B. Gibson, Huntington.
Third Vice-President: James S. Cooley, Glen Cove.
Secretary: Robert J. Morrison, Brooklyn.
Treasurer: Arthur H. Terry, Patchogue.
Historian: Joseph H. Hunt, Brooklyn.
Chairman Ex. Committee: Calvin F. Barber, Brooklyn.

1900-1901.

President: James M. Winfield, Brooklyn.
First Vice-President: William B. Gibson, Huntington.
Second Vice-President: Calvin F. Barber, Brooklyn.
Third Vice-President: James S. Cooley, Glen Cove.
Secretary: Charles Dwight Napier, Brooklyn.
Treasurer: J. Ensor Hutcheson, Rockville Centre.
Historian: Joseph H. Hunt, Brooklyn.
Chairman Ex. Committee: John E. Sheppard, Brooklyn.

1901-1902.

President: William B. Gibson, Huntington.
First Vice-President: Calvin F. Barber, Brooklyn.

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Second Vice-President: James S. Cooley, Glen Cove.
Third Vice-President: William H. Ross, Brentwood.
Secretary: James Cole Hancock, Brooklyn.
Treasurer: John P. Heyen, Northport.

1902-1903.

President: Calvin F. Barber, Brooklyn.
First Vice-President: William H. Ross, Brentwood.
Second Vice-President: J. Frank Valentine, Richmond Hill.
Third Vice-President: Robert J. Morrison, Brooklyn.
Secretary: James Cole Hancock, Brooklyn.
Treasurer: John P. Heyen, Northport.

1903-1904.

President: William H. Ross, Brentwood.
First Vice-President: J. Frank Valentine, Richmond Hill.
Second Vice-President: Robert J. Morrison, Brooklyn.
Third Vice-President: William B. Savage, East Islip.
Secretary: James Cole Hancock, Brooklyn.
Treasurer: Henri M. Auger, Jamaica.

1904-1905.

President: Robert J. Morrison, Brooklyn.
First Vice-President: J. Ensor Hutcheson, Rockville Centre.
Second Vice-President: William B. Savage, East Islip.
Third Vice-President: Elias H. Bartley, Brooklyn.
Secretary: James Cole Hancock, Brooklyn.
Treasurer: Charles B. Bacon, Brooklyn.

1905-1906.

President: William B. Savage, East Islip.
First Vice-President: Elias H. Bartley, Brooklyn.
Second Vice-Pres.: J. Ensor Hutcheson, Rockville Centre.
Third Vice-President: Arthur H. Terry, Patchogue.
Secretary: James Cole Hancock, Brooklyn.
Treasurer: Charles B. Bacon, Brooklyn.

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OFFICERS, 1906

President

ELIAS H. BARTLEY

First Vice-President.....J. ENSOR HUTCHESON
Second Vice-President.....H. BEECKMAN DELATOUR
Third Vice-President.....ARTHUR H. TERRY

Secretary

JAMES COLE HANCOCK

Treasurer

CHARLES B. BACON

ROSTER FOR 1906

Ager, Louis Curtis.....Seventieth St. and Third Ave., Brooklyn.
Alderton, Henry A.....142 Clinton St., Brooklyn.
Alleman, Lewis A. W....64 Montague St., Brooklyn.
Allen, J. Glen.....141 Noble St., Brooklyn.
Amador, Martin.....187 Park Ave., Brooklyn.
Anderson, Herbert C.....194 Union St., Brooklyn.
Anderson, Lewis W.....513 Bedford Avenue, Brooklyn.
Anderson, S. F.....765 Union St., Brooklyn.
Applegate, William S....931 Flatbush Ave., Brooklyn.
Arrowsmith, Albert H....170 Clinton St., Brooklyn.
Auger, Henri M.....Jamaica.

Bacon, Charles B.....109 Cumberland St., Brooklyn.
Bailey, Frederick D.....260 Hancock St., Brooklyn.
Baker, Clarence A.....Yaphank.
Baker, Frank R.....540 Bedford Ave., Brooklyn.
Baker, William A.....Islip.
Baldwin, L. C.....Bellport.
Baldwin, L. Grant..... 28 Schermerhorn St., Brooklyn.
Barber, Calvin F.....57 S. Oxford St., Brooklyn.

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Barber, Vincent.....269 Arlington Ave., Brooklyn.
Barber, Herbert L.....Woodside.
Barnes, Irving F.....Oyster Bay.
Barry, John H.....111 Fifth St., Long Island City.
Bates, Ferdinand J.....Setauket.
Bartley, Elias H.....65 S. Portland Ave., Brooklyn.
Beers, Nathan T.....1265 Bedford Ave., Brooklyn.
Belcher, William Nathan..33 S. Portland Ave., Brooklyn.
Bell, Alfred.....37 Linden St., Brooklyn.
Bell, J. Finley.....Englewood, N. J.
Bellows, Charles.....433 Nostrand Ave., Brooklyn.
Bender, Herman P.....683 Bushwick Ave., Brooklyn.
Benjamin, Frank E.....Shelter Island.
Benjamin, John H.....Riverhead.
Bennett, Edward C.....249 Fifty-eighth Street, Brooklyn.
Bennett, Winfield S.....Patchogue.
Benton, Stuart H.....720 Nostrand Ave., Brooklyn.
Bierwirth, Julius C.....253 Henry St., Brooklyn.
Biggam, William H.....Dean St. and Nostrand Ave., Brooklyn.
Birmingham, Francis H..132 Montague St., Brooklyn.
Bishop, E. S.....919 Bedford Ave., Brooklyn.
Blaisdell, Silas C.....500 Bedford Ave., Brooklyn.
Blanchard, Austin J.....Jamaica.
Bloodgood, Joseph F.....Flushing.
Bodkin, Martin L.....290 Clinton Ave., Brooklyn.
Boes, William.....200 Graham Ave., Brooklyn.
Bogart, J. Bion.....423 Washington Ave., Brooklyn.
Bogart, Arthur H.....135 Seventh Ave., Brooklyn.
Bogart, Joseph H.....Roslyn.
Brader, William B.....1198 Bushwick Ave., Brooklyn.
Braislin, William C.....556 Washington Ave., Brooklyn.
Brewster, Richard C.....126 Lefferts Place, Brooklyn.
Brink, Charles G.....State Hospital, Central Islip.
Brinsmade, William B....117 Montague St., Brooklyn.
Bristow, Algernon T.....234 Clinton St., Brooklyn.
Browning, William.....54 Lefferts Place, Brooklyn.
Brundage, Albert H.....1073 Bushwick Ave., Brooklyn.
Brundage, John D.....Westhampton Beach.
Brush, Arthur C.....29 S. Portland Ave., Brooklyn.
Buckley, Charles F.....802 Carroll St., Brooklyn.

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Brush, Barton W.....Woodside.
Bryn, Harold.....313 Sackett St., Brooklyn.
Buist, Geo. L., Jr.....3 Hancock St., Brooklyn.
Bumster, P. H.....36 Ely Ave., Long Island City.
Burnett, Peter V.....170 Keap St., Brooklyn.
Burnett, William J.....129 Third St., Long Island City.
Burns, James E.....Glen Cove.
Butler, Glentworth R.....229 Gates Ave., Brooklyn.
Bulter, William E.....113 Halsey St., Brooklyn.

Caldwell, M. Stuart.....Far Rockaway.
Campbell, William F.....86 Greene Ave., Brooklyn.
Capron, A. J.....Kings Park.
Carey, John J.....287 Hoyt St., Brooklyn.
Carman, Edwin.....Freeport.
Carolan, Eugene J.....946 Bedford Ave., Brooklyn.
Carter, G. Herbert.....Huntington.
Chapman, William L.....19 Lafayette Ave., Brooklyn.
Chase, Walter B.....263 Hancock St., Brooklyn.
Chattle, Thomas H.....Good Ground.
Chick, Edson S.....376 Gates Ave., Brooklyn.
Clark, Frank H.....758 Putnam Ave., Brooklyn.
Clark, Raymond.....310 Clinton Ave., Brooklyn.
Clayland, John M.....252 Rodney St., Brooklyn.
Cocke, William I.....Port Washington.
Coffin, Lawrence.....Bay Shore.
Collins, Burnett C.....645 St. Marks Ave., Brooklyn.
Combes, Abbott C.....Elmhurst.
Combes, Rodney C. F....185 Hancock St., Brooklyn.
Cook, Frederick A.....670 Bushwick Ave., Brooklyn.
Cooley, James S.....Glen Cove.
Corcoran, Walter J.....233A Clinton St., Brooklyn.
Cornwall, Edward E.....1239 Pacific St., Brooklyn.
Corwith, Silas R.....Bridgehampton.
Costello, P. V.....366 Herkimer St., Brooklyn.
Coughlin, Robert E.....286 Forty-seventh St., Brooklyn.
Cox, Charles N.....257 Jefferson Ave., Brooklyn.
Cruikshank, George H...140 Sixth Ave., Brooklyn.

Davis, George H.....1016 Halsey St., Brooklyn.
Davis, Milton B.....Patchogue.

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Deely, George E.....224A Sixth Ave., Brooklyn.
De Forest, Henry P.....150 East 47th St., N. Y. City.
De Lano, Frank T.....Rockville Centre.
Delatour, H. Beeckman...73 Eighth Ave., Brooklyn.
De Lorne, M. F.....344 Jay St., Brooklyn.
Dewing, Oliver M.....L. I. State Hospital, Brooklyn.
Dexter, Thurston H.....411 Hancock St., Brooklyn.
Dickert, John G.....922 Bushwick Ave., Brooklyn.
Dickinson, Robert L.....168 Clinton St., Brooklyn.
Dildine, Frank C.....Port Jefferson.
Donahue, George H.....Northport.
Dow, Horace D.....Maspeth.
Dowd, James H. B.....3923 Ft. Hamilton Ave., Brooklyn.
Dower, Andrew J.....380 Union St., Brooklyn.
Downey, George H.....Great Neck.
Drury, George.....235 Washington Ave., Brooklyn.
Dudley, William F.....32 Livingston St., Brooklyn.
Duffield, Warren L.....99 Berkeley Place, Brooklyn.
Durand, A. Walter.....Brentwood.
Durham, Roger.....671 Vanderbilt Ave., Brooklyn.
Durkee, John W.....Sea Cliff.

Eastman, Frederick E....1452 Dean St., Brooklyn.
Edwards, David.....Easthampton.
Elliott, Robert M.....L. I. State Hospital, Flatbush.
Emery, Z. Taylor.....481 Washington Ave., Brooklyn.
Erdmann, A. F.....408 Ninth St., Brooklyn.
Evans, George A.....909 Bedford Ave., Brooklyn.
Everson, George.....364 Greene Ave., Brooklyn.

Fairbairn, Henry A.....249 McDonough St., Brooklyn.
Faller, George W.....Oyster Bay.
Fensterer, Gustav A.....Floral Park.
Figueira, Mathias.....14 Stuyvesant Ave., Brooklyn.
Finch, F. A.....Amagansett.
Fincke, Charles L.....165 Clinton St., Brooklyn.
Finn, Charles G. J.....Hempstead.
Fiske, Edwin H.....127 Lafayette Ave., Brooklyn.
Fitzgerald, J. F.....Kings County Hospital, Brooklyn.
Fleming, James W.....471 Bedford Ave., Brooklyn.

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Fletcher, Frederick W....Freeport.
Folger, Rupert.....Whitestone.
Foote, Lewis N.....627 Marcy Ave., Brooklyn.
Forbes, George.....710 Vernon Ave., Long Island City.
Foster, Clarendon A.....202 Berkeley Place, Brooklyn.
Foster, J. M.....Valley Stream.
Fowler, P. Van BenschotenCenter Moriches.
Fowler, Russell S.....388 Lafayette Ave., Brooklyn.
Fraser, Homer E.....188 S. Portland Ave., Brooklyn.
French, Thomas R.....150 Joralemon St., Brooklyn.
Frey, Walter G.....116 Third St., Long Island City.
Frischbier, Charles P.....865 Halsey St., Brooklyn.
Frischbier, Otto G.....235 Humboldt St., Brooklyn.
Fuhs, Jacob.....871 Park Place, Brooklyn.

Gallagher, James T.....449 Lafayette Ave., Brooklyn.
Gardiner, Sidney H.....1085 Gates Ave., Brooklyn.
Geis, Norman P.....1325 Pacific St., Brooklyn.
Gibbons, John T.....1297 Bushwick Ave., Brooklyn.
Gibson, H. G., Jr.....Central Islip.
Gibson, William B.....Huntington.
Gildersleeve, Charles P...18 Schermerhorn St., Brooklyn.
Glynn, James P.....474 Ninth St., Brooklyn.
Goodrich, Charles H.....280 Park Place, Brooklyn.
Goodridge, Edwin A.....Flushing.
Gordon, Onslow A.....71 Halsey St., Brooklyn.
Grant, Walter S.....340 Stuyvesant Ave., Brooklyn.
Gray, Joseph F.....10 W. Hammels Ave.,
Rockaway Beach.
Grover, Harvey L.....849 Quincy St., Brooklyn.

Hagenbuch, William H...Kings Park.
Hall, Gordon R.....164 Clinton St., Brooklyn.
Haller, S. F.....291 Stuyvesant Ave., Brooklyn.
Halsey, Hugh.....Southampton.
Halsey, James L.....Islip.
Hamlin, George D.....1260 Pacific St., Brooklyn.
Hancock, James C.....43 Cambridge Place, Brooklyn.
Harding, John R.....Kings Park.
Harrigan, John.....401 Clinton St., Brooklyn.
Harrington, Burt D.....34 Lenox Road, Brooklyn.

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Harrison, Daniel A.....2 Sidney Place, Brooklyn.
Hartranft, J. M.....Southold.
Hatch, Edwin A.....823 DeKalb Ave., Brooklyn.
Hawley, George R.....309 Gates Ave., Brooklyn.
Hegeman, Thomas B.....2603 Newkirk Ave., Brooklyn.
Hendrickson, Samuel.....Jamaica.
Henry, Charles C.....56 Clark St., Brooklyn.
Hewlett, Harold E.....Babylon.
Hewlett, William W.....Babylon.
Heyen, John P.....Northport.
Hicks, Edward E.....295 Stuyvesant Ave., Brooklyn.
Hinckley, F.....State Hospital, Central Islip.
Hoag, David E.....985 Lafayette Ave., Brooklyn.
Hodges, Edward.....156 Halsey St., Brooklyn.
Hodgskin, Edward S.....13 Seventh Ave., Brooklyn.
Holden, Frederick C.....63 Seventh Ave., Brooklyn.
Holly, I. MacMunn.....636 St. Marks Ave., Brooklyn.
Horni, John.....179 Penn St., Brooklyn.
Horton, Lawrence J.....303 Henry St., Brooklyn.
Hotchkiss, Henry T.....146 Halsey St., Brooklyn.
Houghton, Harris A.....Bayside.
Howe, Alexander C.....307 Cumberland St., Brooklyn.
Hoxie, Edward H.....1 Hart St., Brooklyn.
Hubbard, William S.....1138 Bergen St., Brooklyn.
Hoghes, Peter.....467 Bedford Ave., Brooklyn.
Hulse, William A.....Bay Shore.
Humpstone, O. Paul.....92 Greene Ave., Brooklyn.
Hunter, G. S.....Sag Harbor.
Hutcheson, J. Ensor.....Rockville Centre.
Hyde, Clarence R.....126 Joralemon St., Brooklyn.
Hyde, Joel W.....215 Schermerhorn St., Brooklyn.
Hyman, Marcus B.....Central Islip.

Ingalls, James W.....874 Lafayette Ave., Brooklyn.

Jacques, A. D.....Lynbrook.
Jagger, A. W.....410 Amity St., Flushing.
Jameson, P. Chalmers....139 Montague St., Brooklyn.
Jenkins, Charles R.....600 Lorimer St., Brooklyn.
Jennings, John E.....41 Halsey St., Brooklyn.
Jewett, Charles.....330 Clinton Ave., Brooklyn.

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Jewett, Frederic A.....282 Hancock St., Brooklyn.
Jewett, Harold F.....1072 Bergen St., Brooklyn.
Jewett, William A.....380 Vanderbilt Ave., Brooklyn.
Judd, Albert M.....188 Sixth Ave., Brooklyn.

Keil, Peter Q.....170 Barbey St., Brooklyn.
Kene, Joseph A.....64 Greene Ave., Brooklyn.
Kennedy, James C.....762 Willoughby St., Brooklyn.
Kerr, C. Le Grand.....97 Columbia St., Brooklyn.
Kevin, Christopher D....719 Halsey St., Brooklyn.
Kevin, J. Richard.....252 Gates Ave., Brooklyn.
Keyes, James J.....Glen Cove.
Kingman, Robert.....226 Seventeenth St., Brooklyn.
Kirk, F. J.....404 Hamburg Ave., Brooklyn.
Knause, B. F.....1076 Bushwick Ave., Brooklyn.
Koerner, William F.....154 Rodney St., Brooklyn.
Krichbaum, Philip B.....Sayville.
Kuhn, George R.....122 Clinton Ave., Brooklyn.

Lack, C. Eugene.....692 Tenth St., Brooklyn.
Lamadrid, J. J.....412 Greene Ave., Brooklyn.
Lanehart, Louis N.....Hempstead.
Langstaff, J. Elliott.....19 Seventh Ave., Brooklyn.
Langstaff, Lewis G.....175 Sixth Ave., Brooklyn.
Lauria, Leon.....249 Hewes St., Brooklyn.
Lawrence, Andrew W.... 588 Bedford Ave., Brooklyn.
Lawrence, Enoch P.....147 Amity St., Flushing, L. I.
Lee, John A.....23 Revere Place, Brooklyn.
Lester, John C.....179 Schermerhorn St., Brooklyn.
Lewis, Morley B.....Easthampton.
Lewis, Maurice I.....414 Fifty-fifth St., Brooklyn.
Lewis, Stewart.....13 Cambridge Place., Brooklyn.
Lindridge, Edward F.....424 Vanderbilt Ave., Brooklyn.
Lindsay, Walter .....Huntington.
Lippman, Thomas C.....Sag Harbor.
Little, George F.....469 Clinton Ave., Brooklyn.
Little, William A.....923 Bedford Ave., Brooklyn.
Longmore, John A.....26 Schermerhorn St., Brooklyn.
Loper, Arthur C.....Greenport.
Love, Cornelius R.....167 Clinton St., Brooklyn.
Lubrecht, Charles A.....966 Bedford Ave., Brooklyn.

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Lucas, David F.....552 Pacific St., Brooklyn.
Luce, Charles A.....Amityville.
Ludlam, Charles H.....Hempstead.
Ludlum, Walter J.....262 East Fifteenth St., Brooklyn.
Luhrsen, Ernest F.....292 Greene Ave., Brooklyn.
Lutz, Stephen H.....551 Madison St., Brooklyn.

MacClymont, D. C.....Kings Park.
MacCoy, Cecil.....151 Clinton St., Brooklyn.
MacEvitt, John C.....401 Clinton St., Brooklyn.
MacVean, C. H.....1315 Fifty-second St., Brooklyn.
Macumber, John L.....249 Washington Ave., Brooklyn.
MacGilvary, Stanley H...820 Bedford Ave., Brooklyn.
Macy, William A.....Kings Park.
Maddren, William.....1 Hanson Place, Brooklyn.
Maddren, William H.....131 So. Oxford St., Brooklyn.
Malcolm, William J.....Jericho.
Manley, Mark.....261 Monroe St., Brooklyn.
Manly, Bradley F.....Port Jefferson.
Mann, John.....Old Westbury.
Markham, Convas L.....Amityville.
Marsh, Edward F.....448 Ninth St., Brooklyn.
Marshall, Joseph Hall....536 Monroe St., Brooklyn.
Mass, L. Howard.....Elm St. and Orchard Ave., Brooklyn.
Matheson, A. Ross.....37 Seventh Ave., Brooklyn.
Matheson, Sewall.....578 Bergen St., Brooklyn.
Matson, Nathaniel.....415 Greene Ave., Brooklyn.
Mayne, Earl H.....132 Montague St., Brooklyn.
McCammon, F. J.....359 Stuyvesant Ave., Brooklyn.
McClelland, Leflerts A....78 McDonough St., Brooklyn.
McCorkle, John A.....149 Clinton St., Brooklyn.
McDonald, Henry.....Morris Park.
McEntees, Edward J.....93 Lee Avenue, Brooklyn.
McKenna, Henry J.....113 Fifth St., Long Island City.
McKeown, Patrick.....141 Third St., Brooklyn.
MacNamara, Sylvester J..369 Union St., Brooklyn.
McChesney, H. A.....90 Halsey St., Brooklyn.
McNaughton, George.....479 Clinton Ave., Brooklyn.
McQuire, C. F.....503 Clinton St., Brooklyn.
Meeker, Louis E.....44 Linden St., Brooklyn.
Merritt, Frederick C.....Sayville.

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Meynen, George K.....Jamaica.
Mezrbach, Joseph.....108 Eighth Ave., Brooklyn.
Miles, Clarence C.....Greenport.
Miller, F. H.....64 Pennsylvania Ave., Brooklyn.
Miller, Louis H.....109 Halsey St., Brooklyn.
Mills, Henry M.....192A Sixth Ave., Brooklyn.
Moore, E. S.....Bay Shore.
Moore, J. P.....211 Franklin St., Astoria.
Morris, Edward J.....771A Union St., Brooklyn.
Morrison, Robert J.....354 Tompkins Ave., Brooklyn.
Morton, Henry H.....32 Schermerhorn St., Brooklyn.
Munson, Forbes J.....330 Lafayette Ave., Brooklyn.
Muren, G. Morgan.....73 Orange St., Brooklyn.
Murray, Archibald.....69 Remsen St., Brooklyn.
Murray, Edward T.....Central Islip.
Myerle, David.....510 Bedford Ave., Brooklyn.

Nammack, William H....Far Rockaway.
Napier, Charles D.....1273 Bedford Ave., Brooklyn.
Nichols, Louis L.....386 Stuyvesant Ave., Brooklyn.
Niesley, Charles M.....Manhasset.
North, Jr., Nelson L.....150 Hancock St., Brooklyn.
Northbridge, William A..31 Hanson Place, Brooklyn.
Northridge, T. H.....320 Cumberland St., Brooklyn.
Nugent, John.....Southampton.

Oatman, Edward L.....82 Remsen St., Brooklyn.
O'Hanlon, George.....Kings Park.
O'Neill, John H.....291 DeKalb Ave., Brooklyn.
Ordronaux, John.....Roslyn.
Overton, Frank.....Patchogue.
Owsley, Henry F.....259 Amity St., Flushing.

Palmer, Ernest.....155 Clinton St., Brooklyn.
Parker, E. A.....262 McDonough St., Brooklyn.
Pascual, William V.....601 St. Marks Ave., Brooklyn.
Pashayan, U. S.....Kings Park.
Payne, Albert E.....Main St., Riverhead.
Pentlarge, Victor H.....198 Eighth Ave., Brooklyn.
Peterman, Charles P.....809A Greene Ave., Brooklyn.

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Petersen, Christian E....1097 Dean St., Brooklyn.
Peterson, Frederick C....Smithtown.
Pettit, Henry S.....Adelphi College, Brooklyn.
Pilcher, Lewis S.....386 Grand Ave., Brooklyn.
Pilcher, Paul M.....386 Grand Ave., Brooklyn.
Polak, John O.....287 Clinton Ave., Brooklyn.
Pomeroy, Ralph H.....511 Nostrand Ave., Brooklyn.
Pool, William P.....147 Clinton St., Brooklyn.
Preston, E. F.....Amityville.
Price, Henry R.....435 Clinton Ave., Brooklyn.
Price, Walter D.....202 Schermerhorn St., Brooklyn.

Quell, John A.....478 Decatur St., Brooklyn.
Quinn, J. Randolph.....314 Greene Ave., Brooklyn.

Rae, Alexander.....117 Henry St., Brooklyn.
Rankin, John.....600 Jefferson Ave., Brooklyn.
Rankin, William H.....151 Hancock St., Brooklyn.
Rathbun, Nathaniel P....240 Greene Ave., Brooklyn.
Rave, Adolph G.....New Hyde Park.
Rave, Edward G.....Hicksville.
Raynor, Addison.....977 Flatbush Ave., Brooklyn.
Read, Henry N.....228 Clinton St., Brooklyn.
Reeve, Arthur L.....420 Gold St., Brooklyn.
Reynolds, Willard G.....162 Halsey St., Brooklyn.
Roberts, Dudley D.....84 Remsen St., Brooklyn.
Robertson, Victor A.....834 Union St., Brooklyn.
Roe, William H.....Patchogue.
Rogers, Benjamin F.....Eastport.
Rogers, H. Edward.....36 Troutman St., Brooklyn.
Rosanoff, A. J.....Kings Park State Hospital.
Ross, Walter H.....Hewes St. and Lee Ave., Brooklyn.
Ross, William H.....Brentwood.
Royce, Rubert S.....211 Greene Ave., Brooklyn.
Russell, Julian.....368 Adelphi St., Brooklyn.
Ryon, Walter G.....Central Islip.

Sauer, C. T.....284 Sixth Ave., Brooklyn.
Savage, William B.....East Islip.
Schauf, Adam.....198 Vernon Ave., Brooklyn.
Schelling, Henry L.....841 Willoughby Ave., Brooklyn.

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Schoenijahn, W. Carl....822 Union Street, Brooklyn.
Schroeder, William.....339 President St., Brooklyn.
Scofield, Charles E.....72 Lee Ave., Brooklyn.
Scott, Peter.....128 Reid Ave., Brooklyn.
Scovil, William T.....Hillside Ave., Richmond Hill.
Search, Charles J.....168 Putnam Ave., Brooklyn.
Seymour, Wilbur H.....233 Clinton St., Brooklyn.
Shattuck, Jr., Warren S..147 Clinton St., Brooklyn.
Shea, J. D.....427 Eighth St., Brooklyn.
Shepard, William H.....324 Fifty-second St., Brooklyn.
Sheppard, John E.....130 Montague St., Brooklyn.
Sheridan, Joseph P.....36 Johnson Ave., Morris Park.
Sherwell, Samuel.....33 Schermerhorn St., Brooklyn.
Sherwood, Walter A.....562 Bergen St., Brooklyn.
Shipley, Alfred E.....239 Keap St., Brooklyn.
Shoop, Frederick J.....316 Cumberland St., Brooklyn.
Simmons, Warren S.....338 Lafayette Ave., Brooklyn.
Simmons, William.....23 Schermerhorn St., Brooklyn.
Simon, Theodore W.....Kings Park.
Simrell, George W.....190 Clarkson St., Brooklyn.
Skelton, E. W.....296 Sixth Ave., Brooklyn.
Skene, William H.....Portland, Oregon.
Skidmore, Melville.....East Moriches.
Skinner, Barton D.....Greenport.
Skinner, Erasmus D.....Mineola.
Slocum, M. M.....25 Mott Ave., Long Island City.
Smith, George A.....Manhattan State Hospital, Central Islip.
Smith, Edward J.....86 Vernon Ave., Brooklyn.
Smith, Henry Mitchell....64 Montague St., Brooklyn.
Smith, J. Wheeler.....1120 Herkimer St., Brooklyn.
Smuck, J. Carl.....Lawrence.
Snyder, William Halleck..40 Schermerhorn St., Brooklyn.
Somers, James Q.....32 Lafayette Ave., Brooklyn.
Spence, Thomas B.....139 Seventh Ave., Brooklyn.
Squires, James A.....Stony Brook.
Steele, W. J.....Baldwins.
Stickle, Charles W.....130 Montague St., Brooklyn.
Stivers, George L.....303 Vanderbilt Ave., Brooklyn.
Story, Charles B.....Bayside.
Straub, George C.....846 St. Johns Place, Brooklyn.

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Strong, Benjamin G.....434 Jackson Ave., Long Island City.
Sullivan, John D.....74 McDonough St., Brooklyn.
Swalm, William F.....118 Lafayette Ave., Brooklyn.

Taddiken, Paul G.....L. I. State Hospital, Brooklyn.
Tag, Charles H.....168 Keap St., Brooklyn.
Taylor, John M.....438 Third St., Brooklyn.
Taylor, J. Richard.....1275 Bedford Ave., Brooklyn.
Taylor, Stephen L.....644 St. Marks Ave., Brooklyn.
Taylor, Vernon E.....104 Utica Ave., Brooklyn.
Terhune, James J.....169 Adelphi St., Brooklyn.
Terry, Arthur H.....Patchogue.
Thompson, James E.....233 Greene Ave., Brooklyn.
Tilney, Frederick.....47 Pierrepont St., Brooklyn.
Tomes, William A.....500 Classon Ave., Brooklyn.
Townsend, Palmer.....588 Jefferson Ave., Brooklyn.
Trask, James D.....112 E. Thirtieth St., New York City.
Treadwell, George H.....64 S. Portland Ave., Brooklyn.
Truslow, Walter.....168 Clinton St., Brooklyn.
Turrell, Guy H.....Smithtown Branch.
Tuthill, James Y.....100 Fort Greene Place, Brooklyn.

Ullman, Albert E.....Kings Park.

Van Cott, Jr., Joshua M..188 Henry St., Brooklyn.
Van Deinse, A. P.....Sayville.
Vaux, Clarence L.....State Hospital, Central Islip.

Wade, H. A.....495 Greene Ave., Brooklyn.
Wadsworth, Emory M...1270 Pacific St., Brooklyn.
Wagner, John J.....429 Third St., Brooklyn.
Wahlig, Herman G.....Sea Cliff.
Walker, Irving L.....Central Islip.
Walwood, John B.....Wantagh.
Warbasse, James P.....386 Washington Ave., Brooklyn.
Warner, Henry M.....Hempstead.
Warren, David E.....Long Island State Hospital, Flatbush.
Waterman, J. S.....676 St. Marks Ave., Brooklyn.
Waugh, Darwin W.....388 Clinton St., Brooklyn.
Waugh, H. H.....39 Schermerhorn St., Brooklyn.
Webster, Henry G.....162 Halsey St., Brooklyn.
Weekes, William C.....Babylon.

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Wells, Charles E.....Sag Harbor.
West, Calvin B.....State Hospital, Central Islip.
West, Frank E.....172 Clinton St., Brooklyn.
Westbrook, Richard W...1145 Dean St., Brooklyn.
Wetmore, George T.....422 Clermont Ave., Brooklyn.
Wheeler, Edward A.....110 Ross St., Brooklyn.
Wheeler, Robert T.....209 Hewes St., Brooklyn.
White, Henry D.....206 Garfield Place, Brooklyn.
Whitney, Clarence E.....State Hospital, Central Islip.
Wight, J. S.....30 Schermerhorn St., Brooklyn.
Williams, George A.... .449 Hancock St., Brooklyn.
Williams, John G.....753A Union St., Brooklyn.
Williams, Ralph C.....515 Forty-seventh St., Brooklyn.
Wilson, Frank E.....1242 Bushwick Ave., Brooklyn.
Winfield, James M.....47 Halsey St., Brooklyn.
Wood, J. Scott.....172 Sixth Ave., Brooklyn.
Wood, Philip M. 448 Fulton St., Brooklyn.
Wood, Walter C.....1276 Pacific St., Brooklyn.
Woolsey, William C.....88 Lafayette Ave., Brooklyn.
Wright, Edward W.....115 Montague St., Brooklyn.
Wunderlich, F. W.....165 Remsen St., Brooklyn.

Yerdon, Charles F.....1276 Herkimer St., Brooklyn.

Zabriskie, William H.....Glen Cove.
Zimmerman, Victor L....557 Halsey St., Brooklyn.

HONORARY MEMBERS

George Henry Fox.....616 Madison Avenue, New York City.
Paul Eugene Jones.....Legal Counsel, Mechanics' Bank Bldg., Brooklyn.
Wm. James Morton.....19 E. Twenty-eighth St., New York City.
Theodore Roosevelt.....President of the United States.
George G. Scott.....College City of New York.
Leonard Wood.....Major General United States Army.

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ROSTER FOR 1906

CONTAINING THE NAMES OF THOSE MEMBERS OF THE ASSOCIATION LIVING OUTSIDE OF THE BOROUGH OF BROOKLYN, N. Y.

Geographically arranged.

AMAGANSETT
Finch, F. A.

AMITYVILLE
Luce, C. A.
Markham, Convas L.
Preston, E. F.

ASTORIA
Kindred, J. Joseph.
Moore, J. P.
Trask, James D.

BABYLON
Hewlett, W. W.
Hewlett, Harold E.
Weekes, W. C.

BALDWINS
Steele, W. J.

BAYSHORE
Hulse, William A.
Moore, E. S.

BAYSIDE
Houghton, Harris A.
Story, Charles B.

BELLPORT
Baldwin, L. C.

BRENTWOOD
Durand, A. Walter
Ross, William H.

BRIDGEHAMPTON
Corwith, Silas R.

CENTRAL ISLIP
Brink, Charles G.
Gibson, H. G., Jr.
Hinckley, F.
Hyman, M. B.
Murray, E. T.
Ryon, Walter G.
Smith, George A.
Vaux, Clarence L.
Walker, I. L.
West, C. B.
Whitney, C. A.

CENTER MORICHES
Fowler, P. Van B.

EASTHAMPTON
Edwards, David.
Lewis, Morley B.

EAST ISLIP
Savage, W. B.

EAST MORICHES
Skidmore, Melville.

EASTPORT
Rogers, B. F.

ELMHURST
Combes, Abbot C.

ENGLEWOOD, N. J.
Bell, F. Finley.

FAR ROCKAWAY
Caldwell, M. Stuart.
Nammack, William H.

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FLORAL PARK
Fensterer, Gustav A.

FLUSHING
Bloodgood, Joseph F.
Goodridge, Edwin A.
Jogger, A. W.
Lawrence, E. P.
Owsley, Henry F.

FREEPORT
Carman, Edwin.
Fletcher, Frederick W.

GLEN COVE
Burns, James E.
Cooley, James S.
Kingman, Robert.
Wright, F. A.
Zabriskie, William H.

GOOD GROUND
Chattle, Thomas H.

GREAT NECK
Downey, George H.

GREENPORT
Loper, Arthur C.
Miles, C. C.
Skinner, Barton D.

HEMPSTEAD
Finn, Charles G.
Lanehart, Louis N.
Ludlam, Charles H.
Warner, Henry M.

HICKSVILLE
Rave, Edward G.

HUNTINGTON
Carter, G. Herbert
Gibson, William B.
Lindsay, Walter.

ISLIP
Baker, William A.
Halsey, James L.

JAMAICA
Auger, Henri M.
Blanchard, Austin J.
Hendrickson, Samuel.
Meynen, George K.
Wood, Philip M.

JERICHO
Malcolm, William J.

KINGS PARK
Capron, A. J.
MacClymont, D. C.
Macy, William A.
O'Hanlon, George.
Rosanoff, A. J.
Simon, Theo. W.
Ullman, A. G.

LAWRENCE
Smuck, J. Carl.

LONG ISLAND CITY
Barry, J. H., 111 Fifth St.
Bumpster, P. H.
Burnett, William J.
Forbes, George.
Frey, Walter G.
McKenna, Henry J.
McKeown, Patrick.
Slocum, M. M.
Strong, B. G.

LYNBROOK
Jacques, A. D.

MANHASSET
Niesley, Charles M.

MANHATTAN BOROUGH
De Forest, Henry P.
Trask, James D.

MASPETH
Dow, Horace D.

MINEOLA
Skinner, Erasmus D.

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MORRIS PARK
MacDonald, Henry.
Sheridan, J. P.

NEW HYDE PARK
Rave, Adolph E.

NORTHPORT
Donahue, George H.
Heyen, John P.

OLD WESTBURY
Mann, John.

OYSTER BAY
Barnes, Irving F.
Faller, George W.

PATCHOGUE
Bennett, Winfield S.
Davis, M. B.
Edwards, Lawrence S.
Overton, Frank.
Roe, W. H.
Terry, Arthur H.

PORT JEFFERSON
Dildine, Frank C.
Manly, Bradley F.

PORTLAND, ORE.
Skene, William H.

PORT WASHINGTON
Cocke, William I.

RICHMOND HILL
Mass, L. Howard.
Scovil, William T.

RIVERHEAD
Benjamin, John H.
Payne, Albert E.

ROCKAWAY BEACH
Gray, Joseph F.

ROCKVILLE CENTRE
DeLano, Frank T.
Hutcheson, J. Ensor.

ROSLYN
Bogart, Joseph H.
Ordronaux, John.

SAG HARBOR
Wells, Charles E.
Hunter, G. S.
Lippman, T. C.

SAYVILLE
Krichbaum, Philip B.
Merritt, Frederick C.
Van Deinse, A. P.

SEA CLIFF
Durkee, John W.
Wahlig, Herman C.

SETAUKET
Bates, J. F.

SHELTER ISLAND
Benjamin, Frank E.

SMITHTOWN
Peterson, F. C.
Turrell, Guy H.

SOUTHAMPTON
Halsey, Hugh.
Nugent, John.

SOUTHOLD
Hartrauft, J. M.

STONY BROOK
Squires, James A.

VALLEY STREAM
Foster, A. J.

WANTAGH
Walwood, John B.

WESTHAMPTON BEACH
Brundage, J. D.

WHITESTONE
Folger, Rupert.

WOODSIDE
Barker, Herbert L.
Brush, Barton W.

YAPHANK
Baker, Clarence A.

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